

Ativas Limited - Cairnfield House

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Ativas Limited
Premises audited:	Cairnfield House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 January 2022 End date: 12 January 2022
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	83

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Cairfield House provides rest home and hospital level care for up to 88 residents. On the day of the audit there were 83 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures; a review of residents' and staff files; observations; and interviews with residents, family, management, staff, and a general practitioner.

The facility manager is supported by a clinical manager and registered nurses who provide oversight of clinical care. The residents, relatives and general practitioner interviewed spoke highly of the care and support provided.

The service has addressed three of the four previous audit shortfalls around corrective actions, restraint assessments and restraint interventions. There is an ongoing shortfall around restraint monitoring.

This audit has identified a further six shortfalls around performance appraisals, staff shortages, neurological observations, completion of interRAI assessments, medication competencies and monitoring of water temperatures.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Interviews with residents and family confirmed they are provided with adequate information and that communication is open. Family members stated that they are informed of any change of care or incident related to their family member when this occurs.

Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints with these investigated in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a facility manager and clinical manager who provide operational and clinical management for the service respectively. The district health board has also been supporting the service as a result of the shortage of nurses nationwide.

There is an implemented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by the nurse lead and/or clinical facility manager. All aspects of the quality programme are discussed at relevant meetings with documentation showing resolution of issues in a timely manner. The health and safety programme is implemented.

Policies related to human resources are documented with all staff having a signed agreement and evidence of the recruitment process. An orientation programme is in place for new staff and an annual staff education and training plan is well attended.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurse or enrolled nurse is responsible for assessments, care plans, interventions, and evaluations. Risk assessment tools including interRAI assessments and monitoring forms were documented. The general practitioner reviews residents at least three-monthly. Other allied health professionals are involved in the care of residents.

An activities coordinator and diversional therapist coordinate and implement an activity programme that meets the abilities and individual recreational needs of all residents. There are integrated group activities such as entertainment and regular outings into the community.

There are medicine management policies documented that meets legislative requirements. Medications are stored appropriately. The medication charts reviewed meet prescribing requirements and had been reviewed at least three-monthly.

All meals and baking are prepared and cooked on site by qualified cooks. Resident's individual dietary needs and dislikes were identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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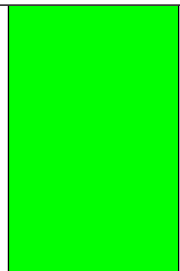
The building has a current warrant of fitness. Ongoing maintenance issues are addressed. There is adequate room for residents to move freely about the home using mobility aids. Outdoor areas are safe and accessible for the residents and shade is provided. There is adequate equipment for the safe delivery of care.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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There is a documented policy around restraint minimisation and use of enablers. The restraint coordinator maintains a register of any resident using a restraint or enabler. The service had five residents using a restraint, and one an enabler. Staff receive education and training in restraint minimisation and managing challenging behaviours. Assessments and plans related to restraint are well documented.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	11	0	4	3	0	0
Criteria	0	38	0	4	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during entry to the service. Complaints forms are located at reception. A register of all complaints received is maintained. There have been six complaints received in 2021 and no complaints in 2022 (year to date). Documentation including follow-up letters and resolution demonstrated that complaints are well-managed with most complaints managed on the day of the complaint being made.</p> <p>Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly. None of the family or residents interviewed had any complaints or concerns about the service but all thought that these would be addressed in a timely manner if raised.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Eight residents were interviewed during the audit (five requiring hospital level of care and three using rest home level of care including one young person with a disability (YPD). Two family members with residents requiring hospital level of care were also interviewed.</p> <p>The auditors also interviewed the facility manager, clinical manager; seven healthcare assistants including four identified as TL4 (senior caregivers), one enrolled nurse, two registered nurses, an activities coordinator, the cook and two administrators.</p>

<p>conducive to effective communication.</p>		<p>There is an open disclosure policy. The policy also describes that open disclosure is part of everyday practice. The care staff and managers interviewed understood about open disclosure and providing appropriate information and resource material when required. Evidence of communication with family/whānau is recorded in the residents' progress notes.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Eighteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event or documentation that the family had chosen not to be notified unless there was an admission to hospital.</p> <p>Residents and family interviewed confirmed that they were well informed about Covid-19 and the processes put in place to support them and their family.</p> <p>An interpreter service is available and accessible if required through the Citizens Advice Bureau. Families and staff are utilised in the first instance and a number of staff also speak other languages.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The facility is owned by Ativas Limited and is operationally managed by a facility manager. Cairnfield House can provide care for up to 88 residents at rest home and hospital (medical and geriatric) levels of care. There are 26 rest home beds, 20 hospital only beds and 42 dual-purpose beds (including two rooms able to cater for two residents in each).</p> <p>There were 83 residents on the day of audit. This included 18 requiring rest home level of care (including one resident under an ACC contract using respite level of care and one resident requiring respite care under the Age-Related Residential Care contract (ARRC); two younger persons with a disability (YPD); and two residents under a long-term support – chronic health care contract (LTS-CHC). There were 65 residents requiring hospital level of care including two under an ACC contract, two YPD, and two LTS-CHC. All other residents were under the ARCC.</p> <p>An annual plan has been developed in the past year that includes a philosophy, values, and measurable goals. Goals documented for 2020 were signed off as completed and the current plan for 2021 – 2022 is being progressed.</p> <p>The facility manager was appointed to the role in September 2013 and is supported by a clinical manager who is a registered nurse (RN) with a current practising certificate and experience in the aged residential care industry. Both managers have completed at least eight hours of training related to management of an aged care facility, relevant to their role and responsibilities. The facility and clinical manager have continued to provide leadership and operational management to the service with a focus on maintaining business as usual despite the impact of the Covid-19 pandemic, staff shortages with difficulties continuing around recruitment of registered nurses particularly, and the introduction of an electronic resident management system recently. The managers are</p>

		supported by registered nurses (RNs) who have taken a leadership role in the organisation.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management programme is in place. Interviews with the facility manager, clinical manager, care staff and household staff reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>There are policies and procedures in place with these relevant to the service types offered. All have been reviewed as per schedule (i.e., updated at least two yearly or sooner if there is a change in legislation, guidelines, or industry best practise).</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Quality improvement data is discussed at monthly staff meetings, and other relevant meetings such as quarterly infection control, health, and safety meetings. Registered and enrolled nurse meetings are held monthly to discuss clinical issues. An administrator has taken on a role as internal auditor and the audits are completed as per schedule with all corrective action plans documented with evidence of resolution of issues in documentation reviewed. The shortfall identified at the previous audit around corrective action planning and resolution of issues has been addressed.</p> <p>Residents and family are able to discuss issues and raise concerns through the monthly resident/family meetings and through annual surveys. The last surveys (resident and family) were completed in March 2021 with a high level of satisfaction. The data for both surveys was collated and trends were compared with the previous year.</p> <p>Hazards are identified, managed, and documented on the hazard register. There is a designated health and safety officer. Health and safety issues are discussed at monthly quality/staff meetings with action plans documented to address issues raised. Health and safety meetings are also held quarterly. Falls prevention strategies include the use of sensor mats and implementing strategies for frequent fallers.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their</p>	FA	<p>An accidents and incidents reporting policy is in place. There was evidence to support actions are undertaken to minimise the number of incidents. Accident and incident forms were evaluated. Clinical evaluation of residents following an adverse event is conducted by a registered nurse with documentation including neurological observations completed for residents following an unwitnessed fall.</p> <p>Adverse events are linked to the quality and risk management programme. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events.</p> <p>The facility manager is aware of the requirement to notify relevant authorities in relation to essential notifications.</p>

family/whānau of choice in an open manner.		One section 31 notification tabled the shortage of nursing staff on one day and another sent in December 2021 tabled the potential impact on the service of a shortage of RNs that was expected to hit the service in 2022. The portfolio manager and DHB consultant attended the closing meeting at the audit and are supporting the service to address issues (link 1.2.8.1).
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one registered nurse, one cook, and four healthcare assistants including two identified as TL4), evidenced implementation of the recruitment process, employment contracts, and a completed orientation. Annual performance appraisals were not current. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. There is an annual education plan that has been fully implemented in 2021 with a high attendance rate for each session. Competencies are completed (link 1.3.12.3).</p> <p>There are 27 healthcare assistants (HCAs) who have not completed Careerforce training; three have completed level two training; 12 have completed level three training and 17 have completed level four training. Four of the six registered nurses and the clinical manager have completed interRAI training.</p> <p>There are total of 52 HCAs. There are 14 HCAs identified as TL4 (i.e., team leader with a level four Careerforce certificate). TL4 HCAs do not carry a resident load but complete tasks to support staff on the floor. This includes administering medications, doing dressings, helping staff on the floor when required (e.g., to transfer a resident etc). The service used to have a team leader role; however, this has been changed to support both HCAs and the RNs because of the nursing shortage. A job description and training plan for the TL4 staff is documented and has been implemented. Three of the five TL4 HCAs are relishing the role. All stated that they had been trained in the additional responsibilities.</p> <p>Residents and family members stated that staff are knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	PA Moderate	Policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the 83 residents. The clinical manager works Monday to Friday. In addition to the clinical manager there are two registered nurses rostered on a morning shift. On an afternoon shift, there are two registered nurses and one registered nurse on overnight. The clinical manager is currently on leave and the service is clinically overseen by two registered nurses. One of the registered nurses who is providing clinical oversight was interviewed. They were knowledgeable and able to provide information for the audit quickly and succinctly.

<p>and/or experienced service providers.</p>		<p>On an AM and PM shift there are eleven healthcare assistants rostered on for full shifts, one short shift on both mornings and afternoons and five rostered on nights. There is a house assistant on in the morning and afternoon shifts. Extra staff can be called on for increased resident requirements.</p> <p>Activities staff are rostered on five days a week. There are separate domestic staff who are responsible for cleaning and laundry services. A physiotherapist was able to be contracted to provide services, however that physiotherapist is no longer able to be contracted and the service is working to find an alternative contractor.</p> <p>Interviews with residents and family members identified that staffing is adequate to meet the needs of residents currently; however, there are nursing shortages. The service has tried to recruit nurses to Cairnfield House without success. There are five RNs employed with 13 nurses making a full compliment. The service has been communicating with the DHB to try and put a plan in place to manage the facility. Currently there have been sufficient nurses to maintain the expected one registered nurse on each shift. The plan in place has included training the level four caregivers to take on TL 4 responsibilities as described in 1.2.7 with this freeing up the registered nurse to focus on specific tasks. It is expected that night shift may not have a registered nurse on site in the future. Nurses at the moment have stated that they will sleep on site so that they can be woken at any time to respond to requests.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Twelve medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. There are documented competency requirements for all clinical staff (RNs and senior HCAs) who administer medications, however these were not current for all staff needing them. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. The registered nurse and senior HCA interviewed could describe their role regarding medication administration.</p> <p>The service currently uses robotic sachet packs for regular medication and 'as required' medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All medications are checked weekly and signed on the checklist form. All eyedrops have been dated on opening. There was one resident self-medicating on the day of audit, with appropriate assessment, review, and medication storage in place. There were no standing orders in use and no vaccines stored on site.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>All meals at Cairnfield House are prepared and cooked on site. There is a food control plan expiring March 2022, and the kitchen has a council "A" grade rating which expires on 31 May 2022. The service has two cooks who cover Monday to Sunday and one kitchen assistant in the morning and one in the afternoon. The head cook oversees the procurement of the food and management of the kitchen. Meals are served in each of the three</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>units from bain-maries with end-cooked and serving temperatures being taken on each meal. These are within the required safe ranges. Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing. Chiller and freezer temperatures are taken daily and are all within the accepted ranges. Cleaning schedules are maintained. All foods were date labelled in the pantry, chiller, and freezers.</p> <p>Food surveys and one-to-one interaction with kitchen staff in the two dining rooms allow the opportunity for resident feedback on the meals and food services generally. There is a six-weekly seasonal menu with dietitian review and audit of menus. The menu is adapted to ensure resident's food preferences are considered.</p> <p>Adapted cutlery, sipper cups and lipped plates are available for resident use. Dietary profiles are completed on admission and likes and dislikes and any changes to dietary needs are communicated to the kitchen via the RN/EN. A dietitian is available on request. Supplements and fortified foods are provided to residents with identified weight loss issues. The head cook (interviewed) was familiar with all residents' likes and dislikes and those residents with specific dietary needs.</p> <p>Relatives reported that meals are well presented, and that staff assist those residents who require help with food and fluid intake.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Residents' care plans are completed by the RN and EN. When a resident's condition alters, the RN initiates a review and if required, GP or mental health services consultation. Short term care plans are documented for all acute needs, which are reviewed appropriately and either resolved or ongoing concerns are included in the long-term care plan.</p> <p>A physiotherapist, dietitian and wound nurse specialist are available by referral and a podiatrist visits residents' regularly. The older persons' mental health team are readily available as required.</p> <p>The family members interviewed stated they are kept informed of the resident's health status and have the opportunity to meet with the GP if required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and the continence products that are required are identified.</p> <p>Adequate dressing supplies are available. Wound management policies and procedures are in place and weights are recorded at least monthly. The wound register currently includes ten skin tears, two blisters, three cancerous lesions and three diabetic ulcers. There were five stage 2 pressure injuries; one community acquired and two end of life/general organ failure, three were facility acquired. Wound dressing charts were being completed, and all wounds had wound assessments/care plans documented.</p> <p>There is a comprehensive range of monitoring forms available for use on the electronic clinical record, including intentional rounding, repositioning charts, and restraint monitoring (link 2.2.3.4), however neurological</p>

		observations were not completed as per policy requirements.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is a diversional therapist and an activity coordinator who plan and lead all activities, covering Monday to Saturday for both rest home and hospital, with Sundays being kept free for family time, church services and visiting entertainers. Residents were observed participating in planned activities in both areas during the time of audit, including group exercise in the main lounge, with the activities team adapting exercises to the various abilities of the clients to facilitate a fun and inclusive session.</p> <p>There is a weekly programme distributed to each resident and written in large print on whiteboards throughout the facility. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, pet therapy, floor games and bingo.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage are offered.</p> <p>There are regular outings including supported shopping trips, and weekly café visits. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as various church denominations and volunteers who play bowls and cards with the residents.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Younger residents (YPD) have individualised activity plans that take account of their age and abilities. They are encouraged to participate in all activities and have taken leadership roles in some resident activities such as summertime sausage sizzles.</p> <p>Residents interviewed were very positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	FA	<p>Three of six resident care plans reviewed (excluding the resident on respite and two recent admissions) had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. All short-term care plans had been reviewed and ongoing issues were included in the long-term care plan. Care plan evaluations were documented and reviewed progress to meeting goals. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so.</p>

timely manner.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The building holds a current warrant of fitness which expires on 23 June 2022. Fire equipment is checked by an external provider. Facility records evidenced a reactive and preventative maintenance programme. Electrical equipment has been tested and tagged. There is a documented procedure for hot water temperature monitoring in resident areas and at hot water cylinders, however this has not been completed since mid-2020.</p> <p>The corridors are wide enough around the facility with handrails available to promote safe mobility. Residents were observed moving freely around the facility with mobility aids where required.</p> <p>There is sufficient equipment available to staff in all areas that is calibrated annually; next due 17 November 2022.</p> <p>There are outdoor areas with seating and shade.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Cairnfield House infection control manual. Effective monitoring is the responsibility of the infection control coordinator (registered nurse). An individual resident infection report is completed for all infections which includes signs and symptoms of infection, treatment, follow-up, review, and resolution. Short-term care plans are used for residents diagnosed with infections as evidenced in the resident files reviewed. Surveillance of all infections are documented, collated and any trends analysed.</p> <p>The infection control coordinator shares infection control data, trends and relevant information to the management and care staff. Areas for improvement are identified, corrective actions developed and followed up. This data is monitored and evaluated monthly. If there is an emergent issue, it is acted upon in a timely manner. There have been no outbreaks since the last audit.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents and all staff have received both doses of the Pfizer Covid-19 vaccine. Residents and staff are offered the influenza vaccine. Covid-19 scanning/manual sign in is mandatory on entry to the facility and the use of face masks is required as part of red alert level restrictions.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP and DHB who both advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p>
Standard 2.1.1: Restraint minimisation	FA	The restraint policy includes the definitions of restraint and enablers and restraint procedures. The education and training programme includes regular in-service training on restraint minimisation. Interviews with the care

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>staff confirmed their understanding of restraints and enablers. The service aims to be restraint-free however it is also to meet resident individual needs.</p> <p>Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had one resident using an enabler and five hospital level residents using a bedrail and or lap belt as a restraint. Written consent was provided by the resident for the use of their enabler (bedrail).</p> <p>Staff have completed training around managing challenging behaviour and around the use of restraint and enablers in the past year.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The assessment process includes reference to the use of restraint. Restraint assessments include identification of risks related to the use of the restraint and any assessment of the resident identifies underlying causes for the behaviour or condition, any existing advance directives, whether the resident has been restrained in the past, any history of trauma or abuse, if the restraint will be culturally safe, how restraint use will be ended and possible alternatives. Two files reviewed where restraint was in use included an assessment that showed that restraint had been identified as a need. Both files included documentation of any risks related to the use of the identified restraint. The shortfall identified at the previous audit has been addressed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Low</p>	<p>Before resorting to the use of restraint, the restraint coordinator utilises other means to prevent the resident from incurring injury, for example, the use of sensor mats. Consent for the use of restraint is signed by the general practitioner, family, and the restraint coordinator. Restraints are incorporated in the long-term care plans and reviewed at least six-monthly. Both files reviewed where restraint was used had documentation in the long-term care plan that provided interventions and reasons for the restraint. The restraint register is up to date. The shortfall identified at the previous audit in this criterion around documentation of strategies and interventions relevant to the assessment has been addressed, however, the restraint file reviewed did not evidence checks of restraint while in use.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	Staff are expected to have an annual performance appraisal. Six files reviewed did not show evidence of a current appraisal being completed. The managers are aware of the shortfall but stated that they have had significant pressures on time that has impacted on their ability to complete these.	Six of six staff files did not include a current annual performance appraisal.	<p>Ensure that each staff member has an annual performance appraisal completed.</p> <p>180 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Moderate	There have been 13 nurses employed at Cairnfield House up until the past year where the service has found it unable to recruit. There are five nurses employed to ensure that there is one nurse on each shift (i.e., one nurse over a 24-hour period on duty). The service has communicated with the DHB who attended the closing meeting of the audit. While the service	The compliment of five nurses is not sufficient to ensure that there is one registered	Implement the plan developed by the service with support from the DHB to address the current staffing shortage and continue to try and

		has managed to cover each shift up until the day of the audit, the next weeks roster showed gaps and the service was unable to fill these.	nurse on duty 24 hours a day.	recruit into the vacant positions. 90 days
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Moderate	There are documented policy requirements relating to competency to administer medications, however not all staff administering medications had a current annual competency.	Six of seven registered nurses (including clinical manager), two of three enrolled nurses, and two of four HCAs who administer medications did not have a current medication competency.	Ensure all staff who administer medication have a current medication competency. 30 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	All six resident files reviewed documented assessments and a care plan using the organisation's electronic template. However, interRAI assessments were not completed within the required timeframes. The registered nurse shortage has impacted on the ability of RNs to keep up to date with completion of interRAI assessments.	One new interRAI assessment was not completed within the timeframes stated in policy for a hospital level resident. Three	Ensure all new interRAI assessments are completed within the required timeframes according to policy. Ensure all routine interRAI assessments are evaluated/updated

			hospital level routine interRAI assessments were not completed within the timeframes stated in policy.	within the required timeframes according to policy. 90 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	There is a documented policy relating to neurological observation requirements, however this policy was not consistently followed.	Five of five unwitnessed falls reviewed showed neurological observations were not completed according to policy.	Ensure all neurological observations are fully completed in a timely manner and according to policy. 60 days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	There are documented requirements for hot water temperature monitoring in resident areas and at hot water cylinders, however this has not taken place as per policy requirements.	Hot water temperature monitoring has not taken place since May 2020.	Ensure hot water temperature monitoring takes place as per policy requirements. 60 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient</p>	PA Low	The restraint records in two files included reference to all criteria identified in 2.2.3.4 a) to g). Both files reviewed where restraint was	Checks of the restraint when in use	Ensure that checks of a restraint are

<p>detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>		<p>used included documentation of the frequency of monitoring of restraint when this was in use.</p> <p>The service has moved from paper-based resident records to an electronic patient management system (introduced in December 2021). There has been some confusion around how the required checks should be documented. This has meant that the checks reviewed on the new system did not show evidence that monitoring of the restraint when in use was as per the frequency of monitoring of restraint recorded in the care plan. Staff stated that they did complete the checks. The shortfall identified at the previous audit remains, however the risk rating remains as a PA low in recognition of the efforts staff have put into ensure that documentation is completed in sufficient detail to provide an accurate account of the indication for use, intervention, duration, and its outcome.</p>	<p>was not documented as per the care plan on the electronic resident management system.</p>	<p>documented to evidence that these have been completed as per requirements documented in the long-term care plan.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.