

# Te Hopai Trust Board - Te Hopai Home and Hospital

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## Introduction

This report records the results of a Certification 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 Health and Disability Auditing New Zealand Limited, 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:

<b>Legal entity:</b>	Te Hopai Trust Board
<b>Premises audited:</b>	Te Hopai Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 7 February 2017      End date: 8 February 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	149

# Executive summary of the audit

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## 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
	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
	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

Te Hopai is owned by a Trust and provides rest home, hospital (medical and geriatric) and dementia level care for up to 151 residents. There were 149 residents on the day of the audit.

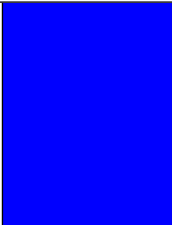
This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board and Ministry of Health. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

Te Hopai has a general manager who is responsible for operational management of the service. She is supported by a large management team including a clinical manager, a quality and training manager, a managing trustee (a board member) and unit managers in the rest home and dementia unit. There are well developed systems that are structured to provide appropriate quality care for residents. Implementation is supported through the quality and risk management programme. There is a schedule of meetings that provide an opportunity for all staff and residents to be engaged in analysis and discussion of issues. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Residents and family members interviewed spoke highly of the services provided at Te Hopai.

This audit has identified no areas requiring improvement.

The service has exceeded the required standard around good practice, infection control management and surveillance, quality management, restraint minimisation, staff orientation and the management of nutritional requirements.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

## 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.		Standards applicable to this service fully attained.
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Te Hopai has a current business plan and a quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme, benchmarking with similar services and a health and safety programme that includes (but not limited to) hazard management. Quality data is used to improve resident outcomes.

Quality information is reported to a variety of facility meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings.

Te Hopai has job descriptions for all positions that include the role and responsibilities of the position. There is an in-service training programme that has been implemented and staff are supported to undertake external training. The staff orientation programme is comprehensive and now allows staff to achieve NZQA standards. There is an annual performance appraisal process in place.

The service has a documented rationale for determining staffing levels. Staff, residents and family members report staffing levels are sufficient to meet resident needs. Staffing can be adjusted to meet current residents' needs and acuity.

## Continuum of service delivery

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.		Standards applicable to this service fully attained.
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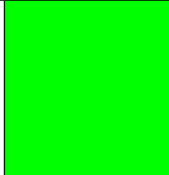
Care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. Care plans are current and reflect the outcomes of risk assessment tools and written evaluations. Families and residents participate in the care planning and review process.

The diversional therapists and activity coordinators provide an activities programme for the residents in the rest home, hospital and dementia care units. The programme is varied, interesting and meets the recreational needs and preferences of the consumer group.

There are policies and processes that describe medication management. Indications for use are clearly documented. Competency assessments for self-medicating residents are in place and reviewed three monthly.

An external contractor is contracted to provide the food service. All meals are prepared on site and the kitchen is well equipped. Residents' food preferences and dietary requirements are identified at admission. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There has been dietitian review of the menu.

## 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.		Standards applicable to this service fully attained.
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Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. Rooms are individualised and uncluttered. Resident rooms are spacious.

External areas are safe and well maintained. The dementia unit and outdoor area are spacious, light and safe. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. The building holds a current warrant of fitness and a preventative and reactive maintenance programme is implemented.

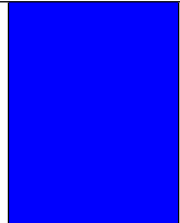
There are spacious lounges within each area. There are adequate toilets and showers for the client group. All resident rooms throughout the facility have full ensuites. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning.

All key staff hold a current first aid certificate. Appropriate training, information and equipment for responding to emergencies is available. There is an approved evacuation scheme and emergency food supplies are held on site and a large supply of water.

Cleaning and laundry services are completed on site and are well monitored through the internal auditing system.

The facility is well laid out and the temperature is comfortable and constant. Residents and family interviewed were very satisfied with the environment.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there were no restraints and nine enablers in place. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

## Infection prevention and control

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.

All standards applicable to this service fully attained with some standards exceeded.

The infection prevention and control coordinator is a registered nurse. The service has infection control policies and an infection control manual to guide practice. The infection control programme is monitored for effectiveness and linked to the quality risk management plan. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.



## 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)
<b>Standards</b>	3	43	0	0	0	0	0
<b>Criteria</b>	7	87	0	0	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. The service provides families and residents with information on entry to the service and this information contains details relating to the Code. Interviews with eight caregivers (two from Owen Street unit [dual-purpose unit], four from the hospital, one from the rest home and one from the dementia unit) and six registered nurses (two from Owen Street [dual-purpose unit], one from the hospital, one from the rest home, one acting dementia care manager and one rest home care manager), four activities staff (two diversional therapists and two recreation officers) showed an understanding of the key principles of the Code. Thirteen residents (six rest home and seven hospital level) and eight families (two hospital level, three dementia level and three rest home level) interviewed confirmed that staff respect privacy and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are</p>	FA	<p>Te Hopai Home and Hospital has policies and procedures relating to informed consent and advanced directives. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p>

<p>provided with the information they need to make informed choices and give informed consent.</p>		<p>Thirteen files reviewed included signed multipurpose informed consent forms for information sharing including taking of photographs, collecting health information and outings as part of the admission process and agreement.</p> <p>There is a resuscitation form and process. Twelve of thirteen resident files reviewed had completed resuscitation documentation (one resident and their family were still consulting and this was clearly documented).</p> <p>There were admission agreements sighted which were signed by the resident or nominated representative. Discussion with families identified that the service actively involves them in decisions that affect their relatives' lives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Advocacy information is part of the service entry package and is on display on noticeboards around the facility. The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is documented on the front page of the resident file. Te Hopai Home and Hospital has a dedicated facility advocate displayed at the facility entrance, a board trustee visits monthly and attends resident's meetings twice yearly, acting as resident advocate. Interviews with residents confirmed that they are aware of their right to access advocacy. There is also an advocate who visits three mornings a week and is available to talk with residents.</p> <p>Interviews with family members identified that the service provides opportunities for the family/EPOA to be involved in decisions. The resident file includes information on resident's family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and family interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Family and friends are encouraged to be involved with the service and care.</p> <p>In 2014, Te Hopai held a support group for wives/husbands who had their spouse in care as they felt there was a need for this kind of support. It was well received, so in 2015 the service decided to hold a relatives' education series for those who had a relative with dementia in their facility (not just a spouse). Te Hopai engaged with the community and used the resources of the Alzheimer's society along with support from the general manager and quality manager. This group enabled the service to educate, teach some basic communication techniques to help make visits enjoyable for both parties and to ensure that for those consumers, who are not able to recognise their rights, have a knowledgeable advocate who could speak for them.</p>

		<p>Family interviewed, state that they are encouraged to be involved with the service and care.</p> <p>Interviews with staff and family reflect that residents are supported and encouraged to remain involved in the community.</p>
<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 service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints.</p> <p>A complaints procedure is provided to residents within the information pack at entry.</p> <p>There is a complaint register that includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented. This includes one complaint to the HDC on 24 June 2016, which the provider was unaware of. A letter was sighted from the HDC on 1 July 2016, stating no further follow-up was required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome information folder that includes information about the Code and there is opportunity to discuss this prior to entry and/or at admission with the resident, family and as appropriate, their legal representative. Large print posters are also displayed throughout the facility. Code of rights, advocacy information on complaints and compliments is brought to the attention of residents and families at admission, in the information pack, via the two monthly resident meetings and six monthly relatives meetings. Interviews with residents confirmed that information has been provided around the code of rights. Te Hopai provides an open-door policy for concerns or complaints.</p> <p>The information pack provided to residents and families on entry to the dementia unit includes how to make a complaint, residents' rights, advocacy and the Health and Disability Commission.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with</p>	FA	<p>The facility provides physical, visual, auditory and personal privacy for residents. During the audit, staff demonstrated gaining permission prior to entering resident rooms. Caregivers interviewed described ensuring privacy by knocking on doors before entering.</p> <p>Interview with residents all stated staff provided a respectful service and were very approachable and friendly. There is an abuse and neglect policy that is implemented and staff are required to complete ongoing abuse</p>

<p>respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>and neglect training. Discussions with residents and family members were extremely positive about the care provided.</p> <p>Thirteen resident files reviewed identified that cultural and/or spiritual values, individual preferences are identified on admission with family involvement and is integrated with the residents' care plans. This includes cultural, religious, social and ethnic needs. Interviews with residents confirmed that their values and beliefs were considered.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The Māori health plan for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. The service has a link with Whānau Care Services and if required refer residents to the CCDHB Māori Health Unit Services (area eg, Capital Coast). Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Residents who identified as Māori confirmed their cultural needs were being met by the service.</p> <p>Discussion with families confirmed that they are regularly involved.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Values and beliefs information is gathered on admission with family involvement and is integrated into residents' care plans.</p> <p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. There are multi-cultural staff available and interviews with residents confirmed that cultural values and beliefs were considered and discussed during preparation and review of the care plan.</p> <p>In early 2015 a policy "LGBTI" was put into place and from this the quality manager searched for some resources to support training of staff. Affinity services were contracted to provide the silver rainbow training. In October 2015, Te Hopai contacted the project lead and arranged to be the pilot facility for training, which they entered into in January 2016. Subsequently in October 2016, they conducted a second training to meet the minimum number of staff trained to meet the standards.</p> <p>Affinity then carried out a review of Te Hopai of their policies, procedures, documentation and did an inspection of the facility. Following this Te Hopai was awarded the Silver Rainbow seal at the end of 2016.</p> <p>Care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities of the position. Interviews with staff and management confirmed their awareness of professional boundaries.</p> <p>Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. During interviews, caregivers could describe how they build a supportive relationship with each resident.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service has policies to guide practice that align with the health and disability services standards. Policies and procedures are well established, cross referenced and reviewed regularly to ensure continuity of care. A formal quality improvement programme has been developed, which includes identification through to sign off. The service employs a skilled quality manager with quality and auditing qualifications. Continuous improvement and quality projects include literature reviews to ensure that all practice and any changes and improvements are evidenced-based and promote best practice. Quality and management meeting minutes demonstrate numerous examples of best practice. The service has exceeded the required standard around good practice.</p> <p>Care planning is holistic and integrated and tool, packs and documents are continually reviewed and improved to allow improvements in care, support and integration.</p> <p>Training plans are in place. Staff development occurs by way of education and in-service training. Careerforce training and in-service training occur. Staff are encouraged and supported to complete external courses and qualifications. The manager undertakes international research trips to research best practice in other settings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in ongoing care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise. This was confirmed in interviews with staff and families, review of resident's files and from a sample of incident forms. The family are notified of GP visits and if unable to attend, they are informed of all the changes.</p> <p>There is an interpreter policy in place and contact details of interpreters were available. The service has multi-cultured staff and residents; registered nurses and caregivers described being able to interpret for some residents when needed.</p> <p>The information pack and admission agreement included payment for items not included in the services. A site-specific introduction to the dementia unit providing information for family, friends and visitors visiting the</p>

		<p>facility is provided to family.</p>
<p><b>Standard 1.2.1: Governance</b></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>Te Hopai Home and Hospital provides hospital (medical and geriatric), rest home and dementia level care for up to 151 residents across four units.</p> <p>The Kowhai dementia unit has 16 beds and was full on audit day with all residents on the age-related care contract (ARCC).</p> <p>The 'Hospital' is a 41-bed unit. On the day of the audit there were 40 residents – 38 at hospital level care on the ARRC contract and one on a 'Like in Age and Interest' contract, and one rest home level resident on the ARCC contract.</p> <p>The Owen Street building (the complex is all one building, with this being the newest addition in 2015) is two levels and all beds in this area are dual-purpose.</p> <p>Level 1 has 21 beds. On audit day, the unit was full. Nine residents were rest home level of care – one on a respite contract and the remainder on the ARCC contract. The remaining 13 residents were at hospital level care with all except one resident who was on a 'Like in Age and Interest' contract, being on the ARCC.</p> <p>Level 2 has 26 beds and was also full on audit day. All except one resident were on the ARCC receiving hospital level care and one resident was on a respite contract at rest home level care. Two residents from this unit were in the public hospital during the audit.</p> <p>The rest home unit has 47 dual service beds. On the day of the audit there were 46 residents, with all residents on the age related care contract (ARCC). There were 19 rest home residents and 27 hospital level care.</p> <p>Te Hopai is owned and operated by a Trust Board with a high level of appropriate skills and expertise. The managing trustee oversees the general manager and provides a liaison point between the general manager and the board. He reported a very high level of satisfaction with the general manager. The organisation chart describes the general manager who has been in the position for 10 years is supported by a clinical manager, a quality and training manager, a rest home care manager and a dementia care manager (on audit day a registered nurse was acting in this role).</p> <p>The management team have maintained at least eight hours annually of professional development activities related to managing a hospital.</p> <p>Te Hopai has both a five-year business plan and a risk management plan. The quality plan is separate from this and is reviewed and rewritten every year. The objective of the quality plan is to ensure that the goals and objectives of service delivery are achieved. These goals are determined by the Ministry of Health standards, the district health board contract and the needs and wishes of the residents and relatives as established by</p>

		the satisfaction surveys that are sent out every year.
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence, the clinical manager undertakes the role of manager. She has extensive aged care experience. She is supported by the managing trustee on behalf of the board, the quality and training manager and the rest home and dementia care managers.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Te Hopai Home and Hospital has a well-established quality and risk management system which is overseen by the quality and training manager (QM). The quality plan includes a variety of quality goals that are developed annually. A comprehensive annual quality review report documents progress toward all goals and reports on all areas of the benchmarking results. An Australasian internal auditing and benchmarking programme is used effectively and results of this and review of data generate ongoing improvements in service delivery. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee (eg, quality). The service is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided via graphs and benchmarking reports. When shortfalls are identified, comprehensive corrective action plans are developed, shared, implemented and reviewed using a PDCA model to ensure these are addressed. The service has exceeded the required standard in this area. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, and to the trust board.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.</p> <p>Key components of the quality management system link to the monthly QM reports through quality reports provided from departments. Monthly reports by general manager to the Board of Trustees provide a coordinated process between service level and board level. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated.</p> <p>In 2016, the service engaged an external consultant to review all health and safety policies and provide training, both at service and governance level. All policies and procedures have been updated in the light of</p>



		<p>the feedback from the review. Health and safety is managed by the GM with the health and safety committee meeting monthly. The service works to a “health and safety vision” through the meetings and the implementation of policies and procedures and day-to-day monitoring by the health and safety committee. Six staff have completed training updates since the April legislation. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Detailed review of falls incidents has resulted to improved documentation around residents at more risk of falling and this has reduced falls in this group.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. A review of 21 incident forms from across all areas demonstrated that individual incident reports are completed for each incident/accident, with immediate action noted and any follow-up action required. The data is linked to the internal benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and all other facility meetings reflected discussion of incidents, trends and corrective actions required (link CI – 1.2.3.6).</p> <p>Two section 31 notifications have been appropriately made since the last audit – one for a medication incident and one for a pressure area. Shortly before the audit Worksafe and the DHB were informed of a visitor incident. The board has identified and made improvements around the shutting of lift doors since this incident.</p> <p>Discussions with service management confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The service maintains a register of registered nurses' and allied health provider's practising certificates. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.</p> <p>Fifteen reviewed files (eight caregivers, four registered nurses (including one acting care manager), one recreation officer, one diversional therapist, one cleaning supervisor) contained evidence of appropriate human resource management practices. All files had up-to-date performance appraisals.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. The programme includes significant dementia</p>

		<p>components, which have been reviewed and are now NZQA approved. Completed orientations were present in all staff files sampled. Staff interviewed could describe the orientation process and stated that they believed new staff were very well orientated to the service.</p> <p>The service employs two staff to oversee education. There is an annual education schedule that is being implemented. External education is available via the DHB. There is evidence in RN staff files of attendance at the RN training days, DHB training, postgraduate education opportunities, hospice training and other external training. A journal club for registered nurses is facilitated by the clinical manager.</p> <p>A competency programme is in place. Core competencies are completed annually or bi-annually depending on requirements. The quality and training manager maintains a comprehensive database to ensure competencies are maintained. The service had identified via the database that activity staff first aid certificates were due but circumstance had meant these were unable to be reviewed prior to the audit. The training was booked and was completed the week following the audit with certificated supplied prior to the completion of the report. As the competency monitoring process is robust and the shortfall had been identified and was comprehensively rectified, no partial attainment has been made around this.</p> <p>There are 10 caregivers that work in the dementia unit. Eight of these and the diversional therapist have completed the required dementia services. The other two have been recently employed. One of these two is a recently graduated registered nurse with a current practicing certificate working as a caregiver and the other is a third-year nursing student.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a roster for each area that aligns with contractual requirements and includes skill mixes. The care managers, clinical manager and general manager reported that the board supports high standards of care and funds staffing to ensure this. This was confirmed by the managing trustee.</p> <p>Several of the management team, including the general manager, education coordinators, clinical manager, rest home and dementia care managers and the quality and training manager are registered nurses.</p> <p>In Owen Street Level one there is one registered nurse on morning shift and one on afternoon shift</p> <p>In Owen Street level two there is also one on morning shift and one on afternoon shift. One registered nurse covers both Owen Street wings overnight and is based on the floor with the highest acuity at that time.</p> <p>In the hospital, there are two registered nurses on morning shift, one on afternoon shift and one on night shift.</p> <p>In the dementia unit, there is the care manager (registered nurse) on duty during the day, during the week.</p> <p>In the rest home, there are two registered nurses and a care manager (registered nurse) on morning shift, and one on afternoon shift and one on night shift.</p> <p>Interviews with relatives and residents all confirmed that staffing numbers were good. Caregivers/registered</p>

		nurses interviewed stated that staffing ratio to residents is good, that they have input into the roster and management were supportive around change when times are busier and resident acuity levels were higher.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident records sampled at Te Hopai contain adequate and appropriate information relevant to the service. Residents entering the service have all relevant information recorded within 24 hours into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Support plans and notes are legible and where necessary signed (and dated) by the registered nurse.</p> <p>Entries are legible, dated and signed by the relevant staff member including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is a policy for resident admissions that includes responsibilities, assessment processes and timeframes. Needs assessments are required for entry to the facility. Te Hopai communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the Code of Consumer Rights, complaints information, advocacy, and admission agreement. Family and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for 13 resident files sampled.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records.</p> <p>There was transfer information sighted in one of the files reviewed, which was noted to be complete, appropriate, and fully documented communicated to support health care staff to meet the needs of the transferring resident.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and</p>	FA	<p>There are medication policies and procedures in place that meet legislative requirements. All clinical staff who administer medications are competency assessed and attend annual medication education provided by the supplying pharmacy. The RNs attend syringe driver training and annual refresher at the hospice. The pharmacy provides the blister packs and these are checked by the RN on delivery. Discrepancies are</p>

<p>timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>reported back to supplier. Standing orders were in place and reviewed annually by the GP. Stock medications are available in two of the five medication rooms and expiry dates are monitored. Each unit has a medication room and medication fridge. The medication fridge temperatures were within an acceptable range. Each area has a locked medication trolley kept in a locked treatment room or cupboard within their unit. All eye drops were dated on opening.</p> <p>Twenty-six medication charts sampled (fourteen hospital, six dementia, six rest home) identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed.</p> <p>The use of 'as required' (PRN) medications are monitored and signed with times when administered. All PRN medications and insulin for residents in the dementia unit are administered by an RN. Staff are required to demonstrate that alternative strategies have been used prior to the use of PRN medication for agitation/aggressiveness. All medication charts sampled had photo identification and allergies/adverse reactions documented. All medication charts sampled met legislative requirements.</p> <p>Medication rounds sighted demonstrated appropriate practice. Administration records had all prescribed medications signed as administered.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>A catering company have the contract to provide meals for the residents at Te Hopai home and hospital. All food is prepared and cooked on the premises. There is a rotational weekly winter and summer menu that has been reviewed by the dietitian. The catering company have recently introduced an electronic device (smiley face touch screen) for monitoring resident satisfaction with meals. There is a chef/site manager, cook and two kitchenhands on duty daily. The main meal is at midday and offers a choice of two main meals. Trolleys with individual meal trays and heat lids are delivered to the unit serveries. The chef receives a dietary requirement form for each new resident admission with documented nutritional needs, likes and dislikes. The chef also receives a daily updated list with individual resident meal choices for the day and specific dietary requirements and any residents with weight loss. Vegetarian, gluten free and modified/soft/pureed meals are provided. Temperature monitoring is carried out on hot food daily. The walk-in chiller, fridges, freezer and dishwasher temperatures are monitored daily. The company who holds the chemical supply contract conduct quality control checks on the dishwasher and monitor chemical usage and effectiveness. Chemicals are stored safely.</p> <p>The chef and cooks are fully qualified. All kitchen staff have been trained in safe food handling and chemical safety.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	<p>FA</p>	<p>The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to</p>

<p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>potential residents is recorded and communicated to the resident/family/whānau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The InterRAI assessment tool was completed within expected timeframes in all resident files sampled. Ten registered nurses have completed InterRAI training and a further three are scheduled for training. Assessments are conducted in an appropriate and private manner. Assessment process and the outcomes are communicated to staff at shift handovers, progress notes, initial assessment and care plans. Resident and families advised that they are informed and involved in the assessment process.</p> <p>The assessment tools link to the individual care plans. Hospital resident's LTCPs have recently been enhanced to link closely to the InterRAI tool with the outcome scores used as the focus of their long-term care plans in two of the thirteen files sampled (these files had used a new template being trialled).</p> <p>Families and residents interviewed confirmed their involvement in assessment processes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. Long-term care plans sampled were reviewed and updated in a timely manner. Interventions were sufficiently detailed to address the desired outcome/goal. Short-term care plans are in use for changes in health status and include interventions and date of resolution were evident in the sampled files. Examples sighted are cares required for wounds, infections, and weight loss. Residents and families confirmed they are involved in the development of long-term care plans.</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>FA</p>	<p>Needs are assessed using pre-admission documentation; doctor's notes, and the assessment tools, which are completed by a registered nurse. Care plans reviewed were goal orientated and reviewed at six monthly intervals. Care plans are updated to reflect intervention changes following review or change in health status as evidenced in twelve of thirteen files sampled (one resident was a respite and did not require review). Residents have the option of choosing the frequency of showering and linen changes including daily assistance.</p> <p>All staff reported that there are adequate continence supplies and dressing supplies. The registered nurses interviewed described the referral process and related form should they require assistance from a wound</p>

		<p>specialist or continence nurse.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the clinical manager and RNs. Continence management in-services have been provided.</p> <p>There were ten skin tears, and four pressure injuries documented in the wound register. Comprehensive wound assessments are carried out with each dressing change and include monitoring the size of the wound, condition of the surrounding skin, exudate, and odour, signs of infection, type and frequency of dressing changes. Wound dressing changes are also recorded in the resident progress notes. The RN assesses and evaluates all wounds. There is access to wound care nurses and specialists as required. Wound care education has been provided.</p> <p>Food and dietary requirements are completed on admission and reviewed six monthly or earlier if required. Residents are weighed monthly. Pain assessments are completed for all residents on pain relief for new or chronic pain. The pain assessments are reviewed at least six monthly or earlier if required. The effectiveness of as required pain relief is documented in progress notes. Pain management is reviewed at the resident reviews with the MDT team.</p> <p>Residents and family members interviewed confirmed the current care and treatments they and their family members are receiving meet their needs.</p> <p>All falls are reported on the resident accident/incident form and reported to the registered nurse and nurse manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral is initiated as required.</p> <p>Monitoring charts such as blood sugar level monitoring, behaviour monitoring, weight charts and effectiveness of pain relief were evidenced in use.</p>
<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>	<p>FA</p>	<p>Te Hopai Home and hospital has two diversional therapists, and three activity coordinators. The team includes an enrolled nurse with extra lesson practitioner qualification and one member with a bachelor of education and a teaching background. They are supported by a group of long-term dedicated volunteers. There is a separate programme for each area (Hospital, RH, Dementia and the Owen dual-purpose unit). One activities coordinator acts as a float assisting with hospital residents. Two staff work full time 32 to 35 hours per week, two work 30 hours a week and one works 24 hours.</p> <p>The team meets weekly to plan the programme and monthly with the clinical manager. The dementia programme runs over seven days and the hospital and rest home over five days. Each unit has specific programme activities that are appropriate to the resident's physical and cognitive needs. The programme is</p>

		<p>proactive and flexible to respond to residents' needs. An example is the introduction of a men's group as the result of feedback. This group has been involved in developing literature to assist new residents to settle and following the disclosure of some members a counselling fund is available to ensure resident's needs are met. Shared activities within the departments are opened to all residents (as appropriate). There is one-on-one time with residents evidenced in the individual monthly progress notes.</p> <p>A community relationship is in place with local kindergartens and schools and a poetry group. Volunteers visit throughout the week and spend time with residents including playing bowls, taking a salsa class, reading and bringing pets to visit. The community van and mobility taxi are used for outings.</p> <p>An activities staff member contacts each resident and their family/whānau within 24 hours of admission. Their activity assessment and lifestyle care plan is developed within three weeks of admission in consultation with the resident/family/whānau. Attendance sheets and individual monthly progress notes are maintained. Residents in the dementia unit have activities to manage behaviours over the 24-hour period documented. Reviews take place every six months or sooner if the resident's needs change. The lifestyle plans for residents in the dementia unit are developed by the RN, activities coordinator and diversional therapist and include all areas of person-centred care.</p> <p>A newsletter (the buzz) is distributed to all residents and reviews recent events with photos and includes upcoming events. Feedback on the programme is received through two monthly resident meetings and regular surveys. Residents interviewed stated they enjoyed the activities, entertainers and outings provided.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident files sampled demonstrated that the long-term care plans were documented and reviewed at least six monthly or as changes occur. Six monthly MDT reviews occur involving the GP, RN, caregiver and relevant allied health professionals involved in the residents' care. The interventions in both long-term and short-term care plans had been updated where the outcomes were different than expected. The interviewed residents and family members reported they were involved in all aspects of care and reviews/evaluations of the care plans.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. The registered nurses interviewed confirm that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted (dietitian).</p> <p>Relatives and residents interviewed stated they are informed of referrals required to other services and are provided with options and choice of service provider.</p>

service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies in place for waste management. There is an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. Product use charts are available. Gloves, aprons, and goggles are available for staff. Interviews with staff described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed).</p>
<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>	FA	<p>The service displays a current building warrant of fitness which expires on 28 June 2017. Hot water temperature checks are maintained at a safe temperature and hot water checks are conducted and recorded monthly by the maintenance person. The service utilise hoists for resident transfer, these have been calibrated and have electrical checks annually. Medical equipment including syringe drivers have been calibrated by an authorised technician. Electrical equipment has been checked and tagged. Interviews with staff confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p> <p>Residents were observed to safely mobilise throughout the facility. There is easy access to the outdoors including a large secure garden in the dementia unit. The dementia unit, including the garden are designed to meet the needs of residents who wander. There are quiet, low stimulus areas that provide privacy when required. The facility is well maintained inside and out and has safe paving, outdoor shaded seating, lawn and gardens.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	FA	<p>Every room in the facility has a full ensuite. Additionally, there are several communal bathrooms and toilets. Residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene.</p> <p>The communal toilets and showers are well signed and identifiable.</p>



<p>facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The rooms are spacious enough to meet the assessed resident needs. Residents can manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Staff interviewed report that rooms have sufficient area to allow cares to take place and staff were seen to use hoists. Residents interviewed are very happy with their rooms. The bedrooms are personalised.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are lounges, smaller seating/quiet areas and dining rooms in each unit. The dining areas are spacious and are easily accessible for the residents. The Kowhai dementia unit has adequate space to allow maximum freedom of movement while promoting safety for those that wander. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed reported they can move around the facility and staff assist them if required.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There is a separate laundry area where all linen and personal clothing is laundered. There are dedicated laundry and cleaning staff. Manufacturer's data safety charts are available. Residents and family interviewed report satisfaction with the laundry service.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Fire evacuation practice documentation was sighted for each area in October 2016. The New Zealand Fire Service has approved the evacuation plan for both buildings (both are connected). Fire training, emergency evacuation and security situations are part of orientation of new staff and ongoing training. Emergency equipment is available. Civil defence boxes are available in each wing (sighted) and are checked regularly. Staff reported coping well following the recent earthquakes in Wellington. The staff stated that they have spare blankets and alternative cooking methods if required. There is food stored for at least three days. There is more than sufficient water stored to ensure for three litres per day for three days per resident. The service has an on-site generator.</p> <p>First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate.</p> <p>There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There is a registered nurse on site available to all residents 24 hours per day, seven days per week.</p> <p>There are emergency management plans in place to ensure health, civil defence and other emergencies are included.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed state the environment is warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be</p>	<p>FA</p>	<p>The role of the infection control (IC) coordinator is held by a senior registered nurse. The IPC team includes representation from throughout the facility. The IPC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the coordinator and infection prevention and control team. IPC is a standing agenda item at the monthly staff meetings and quality meetings (minutes viewed).</p> <p>There is a job description for the IPC coordinator including the role and responsibilities of the position. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine. The service works closely with the medical team to ensure</p>

appropriate to the size and scope of the service.		that antimicrobial use is monitored and used appropriately (link 3.5.1).
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>An experienced registered nurse is the IPC coordinator. IPC matters are taken to all staff, quality and infection control meetings (minutes reviewed). The IPC coordinator can access external DHB, IPC nurse specialist, laboratories, and GPs specialist advice when required. She regularly attends local infection control meetings to keep up-to-date. The coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Te Hopai has infection control policies and an infection control manual, which reflect current practise. The IPC programme defines roles and responsibilities of the IPC coordinator. The IPC programme is reviewed annually by the IPC coordinator and the IPC committee.</p> <p>Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The IPC coordinator has undertaken specialist IPC training. The IPC coordinator attends CCDHB IPC training and update sessions every three months. All new staff receive infection control education at orientation including hand washing and preventative measures. Annual infection control education occurs. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.</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>	<p>CI</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The IPC coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.</p> <p>Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the IPC coordinator. The infection control programme is linked with the quality management programme. Results of infection control data collated is graphed and discussed at staff meetings. Infection control is internally benchmarked which continually compares infection control data gathered.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p> <p>Quality Improvement initiatives are taken and recorded and have resulted in improved outcomes for residents to a level that exceeds the required standard.</p> <p>There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Te Hopai has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers and restraints should these be required.</p> <p>The policy includes that enablers are voluntary and the least restrictive option. There were nine residents with enablers at the time of the audit. Either the resident or their EPOA signs consent to ensure voluntary (sighted in four files sampled). There were no restraints in use at the time of the audit.</p> <p>Strategies are in place to minimise the use of restraint including, sensor mats, hi-low beds, mobility aids and regular observation of residents.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>CI</p>	<p>The service has maintained a restraint free environment despite a high number of hospital level residents. This has been achieved by active review and assessment of all residents and the identification of risks and drivers of behaviour to minimise and address the risks that may otherwise result in the use of restraints. Staff training, staffing levels, proactive care and the support of external agencies support this.</p> <p>The active monitoring of restraint has meant that the service has exceeded the required standard.</p>



## Specific results for criterion where corrective actions are required

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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.

No data to display
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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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Staff, management, resident and family interviews, quality and clinical documentation and observation combined during this audit to provide numerous examples of good practice. The service is continually striving to improve the service provided to residents and their families.</p>	<p>Te Hopai provides an environment that encourages and demonstrates good practice and exceeds the required standard. Two examples included the provision of palliative care and the improved identification of depression and prescribing of antidepressants.</p> <p>In 2016, the service developed a quality goal to ensure that antidepressants were being appropriately prescribed and determined that each time the InterRAI depression score was triggered, this would be followed up by either the use of the Geriatric Depression Scale (GDS) or the GP would note any interventions put in place due to this. An audit was constructed and a review of the InterRAI tool's sensitivity and specificity was conducted. It was discovered that there is concern over the ability of the tool to detect depression. The GP reviewed the prescribing of antidepressants and has been appraising the drug charts and reducing inappropriate prescriptions.</p> <p>A review of six resident records demonstrated that the GDS</p>

			<p>tool has been more specific and sensitive than the previously used InterRAI. All six cases are now having their depression appropriately treated. The number of residents prescribed antidepressants has dropped from 50 in July 2016 to less than 40 by December 2016.</p> <p>At a similar time, the service worked with the GP to reduce polypharmacy. Because of this, the number of residents prescribed nine or more medications, has reduced from 40 in June 2016 to 15 in December 2015.</p> <p>In late 2015, Te Hopai senior staff conducted a review of their palliative care services. Education, including the quality manager attending a palliative care conference, was undertaken and a comprehensive palliative care toolkit was developed that includes culture and spirituality, family meetings and an emphasis on the goals of the consumer. A standardised palliative care audit was undertaken and showed that documentation and implementation of end of life residents increased from 40% in May 2015 to 100% in May 2016.</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>The service benchmarks using an Australasian programme. The benchmarking programme provides comprehensive information, which is reviewed by the management and quality team and quality manager. When unwanted trends are identified, the quality manager undertakes research, including a review of published literature on the subject and accesses any required expertise and then a corrective action plan is developed, implemented and outcomes reviewed to address specific areas where results are outside the desired benchmark or showing an unwanted</p>	<p>The service is proactive in identifying unwanted trends and developing and implementing corrective action plans to address the issue. One of the examples is that in early 2016 quality benchmarking data indicated a higher than desired number of incidents of aggression and undesired behaviours in the resident population, particularly in the dementia unit. Actions include taking a more proactive approach to evaluating and changing care plans of residents involved in incidents and arranging early assessment and interventions from the psychogeriatric team. The psychogeriatric team have provided positive feedback about the quality of the behaviour logs and behaviour monitoring that occurs. Training around dementia including the causes and why people behave the way they do is provided annually instead of bi-annually. The staff attempt to use alternative therapies to reduce behaviour wherever possible, including massage which is funded by the facility. Review of the corrective action plan had identified room to</p>



		trend.	improve, the staff newsletter (Talking Points) was used to convey information about behaviour management to staff so ensure all are aware of and use the same strategies and therefore has introduced consistency in behaviour management. Because of the implementation of the corrective action plan there has been a significant downward trend in 2016 in aggressive incidents toward other residents and aggressive incidents towards staff (benchmarked separately). During the audit, the audit team observed a high level of skill in managing behaviour by staff in a quiet and respectful manner, and staff described a wide variety of techniques they employ.
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	CI	Te Hopai has had a comprehensive orientation programme. The programme includes buddying and completion of Careerforce level one and two service specific education. There are role specific orientations for all roles in the service.	Te Hopai aims to provide the highest quality of experience, care and support to the people who reside there, and their families. To achieve this, they identified that they needed to ensure that staff were not only able to do the job, but that they excelled at holistic resident care. The essential components of the service had been built upon in the orientation programme. They have linked with Careerforce to have the programme recognised as a NZQA accredited qualification. Following a two-year long programme of ongoing improvements and tweaks to the orientation, it was achieved in early 2017 and the service now offers the national certificate in community support level 2 to all their new caregivers. Numerous examples of improvements in care and satisfaction were provided through staff and resident interviews. This included an increase by 6.5% in the residents' independence score in the dementia unit, one of the areas targeted in the orientation.
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs</p>	CI	In early 2016, a need was identified through internal audits and satisfaction surveys to improve their weighing processes, to ensure that the residents were receiving a nutritionally complete diet. The benchmarking process	In early 2016, a need was identified through internal audits and satisfaction surveys to improve their weighing processes, to ensure that the residents were receiving a nutritionally complete diet. The benchmarking process included "unplanned or unexpected weight loss" but the previous charts were hard to read as there was no graphical component to

met.		<p>included “unplanned or unexpected weight loss” but the previous charts were hard to read as there was no graphical component to them. The project involved the development of a new weight chart and trial of the chart in the two Owen Street wings. The weight chart proved to be an efficient and reliable method to quickly calculate if interventions needed to be put in place to manage weight loss. The InterRAI tool calculated this information, but did not translate this into a graphical form.</p> <p>This initiative has improved resident safety by quickly identifying unplanned weight loss and by linking the care plans intimately with the InterRAI assessment, thus improving the planning of care. A review of six residents with unplanned weight loss on audit day determined that four have gained weight, one was identified quickly following a small loss in December 2016 and increased calorific intake has commenced (confirmed also by kitchen staff) and one was identified through the early identification initiative but the weight loss was due to incorrect weighing. Benchmarking results for the second half of 2016 show significant improvement in the management of unplanned or unintended weight loss.</p>	<p>them. The project involved the development of a new weight chart and trial of the chart in the two Owen Street wings. The weight chart proved to be an efficient and reliable method to quickly calculate if interventions needed to be put in place to manage weight loss. The InterRAI tool calculated this information, but did not translate this into a graphical form.</p> <p>This initiative has improved resident safety by quickly identifying unplanned weight loss and by linking the care plans intimately with the InterRAI assessment, thus improving the planning of care. A review of six residents with unplanned weight loss on audit day determined that four have gained weight, one was identified quickly following a small loss in December 2016 and increased calorific intake has commenced (confirmed also by kitchen staff) and one was identified through the early identification initiative but the weight loss was due to incorrect weighing. Benchmarking results for the second half of 2016 show significant improvement in the management of unplanned or unintended weight loss.</p>
<p>Criterion 3.5.1 The organisation, through its infection control</p>	CI	<p>The quality and training manager and infection prevention and control manager undertake research and attend relevant meetings, conferences and</p>	<p>In early 2016, the infection control team identified that 13% of antibiotics prescriptions did not meet the antibiotics prescribing criteria. The service accessed and provided a copy of the antibiotic prescribing guidelines to all GPs to encourage</p>

<p>committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>		<p>trainings to ensure they are aware of current best practice. The service is able to provide funding for their contracted medical practitioners to expand their knowledge if required</p>	<p>appropriate prescribing. Training and collegial support was provided to registered nurses to enable them to feel more able to discuss prescribing practices with the GPs. Because of these interventions there has been a 75% increase in the use of nitrofurantion or trimethoprim as the first line of treatment for urinary tract infections (best practice) and a reduction from 13% to 6% of antibiotic prescriptions that did not meet the guidelines.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>In 2016 the Te Hopai infection control team determined to lower the rate of cellulitis for all residents and UTIs for hospital level residents (who were highest in the statistics). The McGregor form was researched and used to ensure that infections were accurately diagnosed and there was a concentrated and ongoing programme to increase hand hygiene and reduce glove use to protect residents from increased risk of infection. Frequent hand hygiene audits underpinned and monitored this process. The service also researched and sourced high standard training material for staff including video tutorials from the Ontario Public Health programme. Additionally, staff awareness was increased around reducing the risk and incidence of residents bumping and bruising themselves as it was identified that this was a precursor to many of the cellulitis infections. Because of these (and other) interventions the UTI rates in the hospital and two Owen Street wings (hospital) have significantly reduced (evidenced by benchmarking graphs)</p>	<p>In 2016 the Te Hopai infection control team determined to lower the rate of cellulitis for all residents and UTIs for hospital level residents (who were highest in the statistics). The McGregor form was researched and used to ensure that infections were accurately diagnosed and there was a concentrated and ongoing programme to increase hand hygiene and reduce glove use to protect residents from increased risk of infection. Frequent hand hygiene audits underpinned and monitored this process. The service also researched and sourced high standard training material for staff including video tutorials from the Ontario Public Health programme. Additionally, staff awareness was increased around reducing the risk and incidence of residents bumping and bruising themselves as it was identified that this was a precursor to many of the cellulitis infections. Because of these (and other) interventions the UTI rates in the hospital and two Owen Street wings (hospital) have significantly reduced (evidenced by benchmarking graphs) and diagnosed cellulitis dropped from 51 in 2015 to 31 in 2016.</p>

		and diagnosed cellulitis dropped from 51 in 2015 to 31 in 2016.	
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	CI	<p>The service actively reviews all residents at risk, including those who may require restraint use regularly. Proactive review, staff training and orientation and documentation and implementation of alternatives to restraint have meant the service has remained restraint free.</p>	<p>An ongoing goal at Te Hopai is to remain restraint free without compromising the safety of residents. The active monitoring and review of residents who may otherwise require restraint has resulted in a number of interventions to achieve the restraint free environment. This includes comprehensive orientation of new staff that includes mentoring and modelling of appropriate care, including managing falls and monitoring those who are prone to wander, including the reasons residents wander, in training and teaching staff to look beyond a behaviour for the cause, close liaison with families, one-to-one training when required for staff as identified through close analysis of incidents to identify staff who may be struggling to manage challenging behaviour and liaison with external agencies in a prompt manner. Residents at high risk of wandering are also provided with GPS trackers.</p>

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End of the report.