# Heritage Lifecare Limited - Waiapu House

## Introduction

This report records the results of a Provisional 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 The DAA Group 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Heritage Lifecare Limited

**Premises audited:** Waiapu House

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 13 October 2016 End date: 14 October 2016

**Proposed changes to current services (if any):** Provisional audit

**Total beds occupied across all premises included in the audit on the first day of the audit:** 70

# 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.

## General overview of the audit

Anglican Care Waiapu’s Havelock North facility Waiapu House provides rest home and hospital (both geriatric and non-acute medical) level care for up to 74 residents. The service is currently operated by the aged care services arm of the Anglican diocese of Waiapu and is managed by an acting facility manager and a clinical services manager. Residents and families interviewed during the audit spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service’s contracts with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff, contracted allied health providers and a general practitioner.

This audit has identified two areas requiring improvement relating to the number of registered nurses currently able to undertake interRAI assessments and maintaining the currency of staff members compulsory training and competencies.

## Consumer rights

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The facility manager is responsible for the management of complaints, with oversight by the regional manager and Anglican Care Waiapu’s clinical, quality and compliance manager. Complaints forms and information about the organisation’s process are available throughout the facility. A complaints register is maintained and demonstrated that complaints have been resolved within the timeframes required.

## Organisational management

Anglican Care Waiapu is the governing body and is responsible for the service provided at this facility. There are appropriate planning documents to guide the management of the facility. Systems are in place for monitoring the services provided. The facility and clinical manager report to the senior management of the organisation on a regular basis.

The facility is currently managed by an experienced and suitably qualified manager who is the regional manager. There is a clinical manager who has been at Waiapu House since January 2016. The clinical manager is the back up for the facility manager in a temporary absence.

A quality and risk management system is in place which includes collation and analysis of data from adverse events, a calendar of internal audits and clinical indicator monitoring.There is discussion of trends and follow up where necessary.

Meeting minutes, graphs of clinical indicators and benchmarking results are displayed. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A wide range of policies and procedures cover all aspects of service delivery, are current and reviewed regularly, with input from members of the quality/health and safety committee.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme ensures staff are competent to undertake their roles. There is systematic approach to identify, plan, facilitate and record ongoing training and this includes regular individual performance review. The clinical manager has re-introduced the organisation’s compulsory training programme.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster of senior staff on call out of hours. Staff members report that the rostered complement of staff are sufficient to meet resident needs.

A consumer information management system is in place and information entered in a timely and accurate manner. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

A representative for the prospective purchaser was onsite during the audit and was interviewed. They have a detailed transition plan in place which includes appropriate planning pre-and post the sale of the facility.

## Continuum of service delivery

The organisation works closely with the local Needs Assessment and Service Co-ordination Service (NASC), to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff, a podiatrist, physiotherapist, occupational therapist, pharmacist and designated general practitioners. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents’ files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by an activities co-ordinator, provides residents with a variety of individual and group activities and maintains their links with the community. Two facility vans are available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

## Safe and appropriate environment

The facility has been purpose built. All rooms are for single occupancy and have their own ensuite bathrooms. There are identified ‘rest home’ and ‘hospital’ wings but all rooms are designated for dual purpose use and are of adequate size to provide appropriate care.

All building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are spacious and maintained at a comfortable temperature. There are multiple small areas throughout the facility for residents to have privacy and a quiet space, as well as the large dining rooms and lounge areas. Shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and was observed being used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite, with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to an emergency power source is available. Residents report a timely staff response to call bells. A contracted security company monitors the facility each night.

All rooms have large windows which allow natural light and ventilation. Window coverings are in good condition.

## Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Enabler use is voluntary for the safety of residents in response to individual requests. Three residents were using enablers and six residents were using restraints at the time of audit.

Restraint is only used as a last resort when all other options have been explored. An assessment, approval and monitoring process with regular reviews occurs. Staff receive training at orientation and thereafter annually. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes. Similarly, the review of residents’ files and associated documents for the Restraint Approval Group confirmed that the organisation’s systems are implemented and these standards are being met.

## Infection prevention and control

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice is accessed from the district health board (DHB), microbiologist, infectious diseases physician, and group clinical advisory committee. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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 | 49 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 99 | 1 | 1 | 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)** |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Waiapu House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, outings, invasive procedures.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s record. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed at staff interviews. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports the philosophy of Spark of Life, caring and living life to the highest level of independence.  The facility has unrestricted visiting hours and encourages visits from residents’ family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The Anglican Care Waiapu complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there are complaints forms available in a number of locations throughout the facility.  The complaints register and documentation was reviewed and showed that complaints are received, documented and responded to within the timeframes of the Code. Action plans reviewed show any required follow up and improvements have been made where possible.  All staff interviewed confirmed a sound understanding of the complaint process and what actions are required if residents or family members seek assistance.  The 2016 family satisfaction survey includes the question ‘Do staff listen and respond to suggestions and concerns?’, and 80% of respondents scored this as above average or excellent. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The prospective provider Heritage Lifecare Limited (HLL) is an established provider of aged care services. They know and understand the requirements of the Health and Disability Commissioner’s Code of Consumers Rights (the Code). The have appropriate policies and procedures to guide staff in meeting the requirements of the Code and their senior managers similarly understand these requirements.  The HLL Quality and Compliance manager was onsite during this audit and interviewed as part of the audit process.  Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service) through facility manager as part of admission process, information provided, to resident and family/whanau and discussion with staff. The Code is displayed in the rest home and hospital entrance way, in front of the office and nurses’ stations. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit while attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information with residents and their family/whanau. All residents have a private room and ensuite.  Residents are encouraged to maintain their independence by staff ensuring individual care plans are followed, attending community activities, arranging their own visits to the doctor, participation in clubs of their choosing. Each plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs (currently there are no Māori residents). The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences, required interventions and special needs were included in all care plans reviewed. Residents had dietary preferences and spiritual preferences documented, interviews confirmed that staff ensure the residents’ needs are met. A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met and this supports that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, occupational therapist, wound care specialist, community dieticians, services for older people, psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education through the DHB and there is evidence of a compulsory plan for all staff where staff are booked to attend education to support contemporary good practice.  Other examples of good practice observed during the audit include extra fluid rounds, prompt answering of call bells, regular toileting rounds, and pressure injury prevention strategies. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services are able to be accessed via the DHB when required. Staff knew how to do so, although reported this was rarely required due to all residents able to speak English, staff able to provide interpretation as and when needed and the use of family members and communication cards for any potential residents for whom English is not their first language. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Anglican Care Waiapu (Anglican Care) has a strategic plan to 2020 which outlines the purpose, values, scope, direction and goals of the organisation. Each facility is the Anglican care group has an annual business plan with objectives and the associated operational plans which link to the long term strategic plan. The senior management structure of Anglican Care includes a regional manager based in the Hawkes Bay, who is currently the acting facility manager for Waiapu House; the previous facility manager having resigned in September 2016.  The facility manager provides a monthly report against the objectives to a general manager for Anglican Care’s aged care services, which ultimately goes to a board of directors. A sample of reports reviewed shows adequate information to monitor performance is reported including reporting against business and quality plan objectives and risks which require the boards attention.  The service is managed by a facility manager and clinical manager. The acting facility manager is Anglican Care’s Eastland regional operations manager. He has been a senior operational manager in the aged care sector for eight years and has been with Anglican Care Waiapu for the last 2 years.  On the days of the audit there were 67 residents receiving services at Waiapu House, of these 39 were receiving rest home level care, and 28 hospital level care. All bedrooms are designated dual purpose usage in the facility, although there are assigned rest home and hospital wings within the facility.  The clinical manager has been in her position since January 2016. She has a wide range of skills and experience for this role and has a job description which describes the responsibilities of her position and an individual employment agreement. Both incumbents demonstrated their knowledge of the sector, regulatory and reporting requirements of their positions. They are supported to maintain the currency of their skills and knowledge through ongoing training.  In addition to the provision of aged related residential care (rest home care) and aged related hospital specialist services (hospital care), at the time of the audit the service holds contracts with Hawkes Bay District Health Board (HBDHB) for long term serious chronic health conditions, respite and day care services and the ‘Engage’ contract which provides short terms residential and restorative care from five days to five weeks.  The prospective owners – Heritage Lifecare Limited (HLL) provide aged care services in a number of facilities and are familiar with the contracts and requirements. HLL has a detailed transition plan with timelines, appropriate actions and communication. This was sighted during the interview with the quality and compliance manager. They confirmed that the management structure would remain unchanged, with Anglican Care and HLL working together to fill the vacancy in the facility manager’s role as part of the purchase agreement. The prospective owners have notified the funders of their intention to purchase. |
| Standard 1.2.2: Service Management  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. | FA | When the facility manager is absent, the clinical manager carries out all the facility manager’s duties under delegated authority. She is assisted by the available on call person as necessary and by the Anglican Care Waiapu clinical, quality and compliance manager. Anglican Care Waiapu has another facility in Hawkes Bay and assistance can also be provided by the management team from this if required.  During absences of the clinical manager, the clinical coordinator is available to provide clinical oversight. She is an experienced aged care RN, and has been at Waiapu House for six years and is able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.  The HLL quality and compliance manager confirmed that their senior management structure provides a similar support network with her own role and a senior clinical operations manager being available to provide assistance to the clinical manager or clinical coordinator in the absence of either of the managers of the facility. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a quality and risk system that is overseen by the Anglican Care clinical, quality and compliance manager, who is a registered nurse with extensive experience in the aged care sector. There is an annual quality plan for the facility which links to the business plan and has appropriate objectives which guide the activities of the quality/health and safety committee. An annual internal audit programme is implemented, which monitors service delivery and all aspects of the facility’s functions.  There are terms of reference for the quality / health and safety committee and meeting minutes are maintained. The Waiapu House clinical coordinator is responsible for collating adverse event data and providing this information to the monthly committee meetings and to the clinical manager for her monthly reports. Review of the minutes of these meetings for 2016 confirmed that these systems are well imbedded as are the associated processes.  Regular review and analysis of quality indicators occurs and related information is reported and discussed at the weekly management team meetings and monthly quality / health and safety committee meetings. Summaries of this information is shared with staff members at the three monthly staff meetings. Minutes reviewed include discussion on pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results and activities. Staff reported their involvement in quality and risk activities through the current quality improvement projects. One quality improvement project which is providing very useful information is a spreadsheet which tracks interRAI assessment, care plan reviews and medication reviews.  Relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Resident and family surveys are completed annually. The last survey was completed in mid-2016. Overall, respondents’ ratings were either very satisfied or excellent.  Policies reviewed cover all necessary aspects of the service and contractual requirements and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff are updated on new policies or changes to policies through the staff meetings. Copies of new policies were sighted in the staff room with meeting minutes for staff who are unable to attend meetings to review them.  The facility manager and clinical coordinator described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register shows consistent review and updating of risks, risk plans and the addition of new risks. The health and safety coordinator has attended Health and Safety training relevant to her role and the organisation has a range of policies and procedures which include the requirements of the Health and Safety at Work Act (2015) and these are implemented. Documents and records relating to their requirements – hazard reporting and hazard register – were reviewed with the clinical coordinator. The register is reviewed weekly at the management team meeting to ensure that any new hazards are being managed and all existing hazards are mitigated.  The prospective owner has an established quality and risk management system which includes a quality management plan. This will be implemented at Waiapu House should the sale proceed and is included in the transition plan. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Policy and procedures described essential notification reporting requirements. The regional manager/acting facility manager discussed the section 31 notifications which have occurred in 2016, and an example of one of these was reviewed. The clinical manager was interviewed and was familiar with her responsibilities in the organisation’s policy for reporting to the facility manager, who makes the notification. There are no current legislative compliance issues for Waiapu House at the time of this audit.  Staff document adverse events on an accident/incident form. A sample of incidents forms reviewed show these are fully completed, events are investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is collated, analysed and reported to the quality / health and safety committee and meeting minutes reviewed show discussion in relation to trends, action plans and improvements made.  The Anglican Care clinical, quality and compliance manager is included in the trend analysis and receives the monthly data reports. She provides graphed data of quality indicators for each facility in the Anglican Care group so that every facility can benchmark themselves against the others. This information is also discussed at the regional quality committee meetings which occur approximately every two months. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. Recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of personnel files were reviewed. This confirmed the organisation’s policies are being consistently implemented and records are systematically maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a ‘buddy’ through their initial orientation period. Personnel files show documentation of completed orientation and a performance review after a three-months for new staff members.  Compulsory continuing education is planned on an annual basis. Mandatory training requirements are defined and scheduled to occur over the course of the year. Some carers have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider’s agreement with the DHB. However, this is not currently a mandatory part of the Anglican Care Waiapu training programme. Additional information sessions are included in staff meetings to provide updates when a need is identified through internal audits, collated quality improvement data or adverse event data. At interview with staff members they reported receiving sufficient training to perform their jobs safely and well.  The clinical manager and acting facility manager have ensured that staff appraisals and compulsory training are occurring as required. They have developed comprehensive planning documents to record completion of appraisals/training for all staff members and associated competencies. This was done because they identified that they were not up to date. Despite the remedial work already in place there are a proportion of staff who have not yet completed all required training and competencies.  Similarly, the facility now has only two registered nurses (RNs) who can undertake interRAI assessments. There are plans in place to train more RNs but the acting facility manager and clinical manager have already identified that they are unable to stay up to date with their current complement of staff. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of residents, supported by the use of a workload measurement tool.  The clinical manager prepares the roster using an electronic rostering tool. The minimum number of staff is provided during the night shift and consists of two RNs and six caregivers. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.  Staff reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of the roster during this audit confirmed adequate staff cover has been provided. The organisation contracts to a bureau for short notice roster gaps. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage in the hospital.  The HLL quality and compliance manager confirmed that they have a documented staffing policy and they will be maintaining the current staffing ratios at the service. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review.  Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with facility manager (FM) and clinical manager (CM). They are also provided with written information about the service and the admission process. The service operates a waiting list for entry. The organisation seeks updates information from NASC and the GPs for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB’s ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, 24 hours of medication, 24 hours of progress notes, wound charts, and advance directives are provided for the ongoing management of the resident. A checklist ensures this occurs. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility, showed a planned, co-ordinated transfer to the acute care service and transition back again. Family members of the resident reported being kept well informed during the transfers of their relative. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using a manual robotic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.  There were no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.  Medication errors are reported to the clinical manager and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.  Standing orders are not used at Waiapu House. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by the kitchen manager and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the clinical quality and compliance manager. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC service is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC service is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the FM and CM. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools such as pain scale, skin integrity, nutritional screening, falls risk, continence assessment, activity assessment and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents’ files reviewed during the audit had a current interRAI assessment on the days of the audit. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard at Waiapu House. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  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. | FA | The activities programme is provided by one trained activities co-ordinator holding the Careerforce activities co-ordinator certificate, an assistant who has nearly completed the activities certificate, and rostered volunteers.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated as their needs change, monthly and as part of the formal six monthly care plan review.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include musicians playing music and singing, planned outings, individual outings, volunteers coming to read to residents, children’s groups coming to visit. The activities programme is discussed at the minuted residents’ meeting and indicated residents’ input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme encourages them to reach their highest level of independence within the limitations they have. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for urinary tracts infections (UTIs), falls, infections, any changes in the resident’s normal status and progress evaluated as clinically indicated at least weekly and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| 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 service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. All residents have the choice of their own GP. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to the physiotherapist, occupational therapist, needs assessor, gerontology clinical nurse specialist, diabetes nurse specialist, wound care specialist, geriatrician, and older persons’ mental health. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place. These include procedures for waste (blood and bodily fluids) management and disposal.  Appropriate signage is displayed where necessary. During the audit cleaning products and chemicals were observed to be either stored securely or under supervision of a staff member when in use.  An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored. Any related incidents are reported in a timely manner. Cleaning and laundry staff interviewed were familiar with the processes to follow to undertake their roles and were able to describe the products and chemicals used.  There is personal protective equipment (PPE) including aprons, gloves, masks and goggles for use when required. Staff were observed using this equipment. At interview they reported having adequate supplies for routine use and during the recent contaminated water and associated outbreak, which required additional isolation precautions. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expires 1 March 2017) is publicly displayed.  The facility is purpose built and is suitable for the resident population. Appropriate systems are in place to ensure the physical environment and facilities remain fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment. The testing and tagging of equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed and observation of the environment.  External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe.  The acting facility manager and the health and safety coordinator were interviewed and described the maintenance and monitoring systems for the environment. Relevant documentation and records were reviewed and confirmed that the organisation’s systems are being implemented.  All rooms are designated as dual use and all can accommodate people requiring hospital level care. However, within the facility there are assigned hospital and rest home wings, with 32 hospital rooms and 42 rest home rooms.  There is a co-located retirement village with an apartment wing at one end of Waiapu House which was not included in this audit. There is a large lounge / dining room and kitchenette with toilet facilities within the aged care facility which is used by village residents. These facilities are all additional to those of the aged care facility.  The prospective owner has no plans to make structural or environmental changes to the facility. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All residents’ bedrooms have an ensuite bathroom. The bathrooms have a toilet, hand basin and wet area shower. There are appropriate grab rails in the bathrooms to promote residents’ independence and safety.  The facility has adequate numbers of staff and visitor designated toilets throughout the building, with clear signage. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.  There are a number of cupboards and alcoves around the building to store hoists, and other large equipment when it is not in use. Rooms are big enough to accommodate a resident’s personal equipment (mobility aids, walking frames and wheel chairs) without creating a hazard when not in use.  Staff and residents reported the adequacy of bedrooms. In response to the question ‘Is your relative safe and secure at Waiapu House?, ‘in the 2016 family satisfaction survey, there was a 93% response of above average or excellent. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in a range of activities. There are two large dining and lounge areas which are spacious and enable easy access for residents and staff. In addition, there is a library, an activities room and a chapel on site. Residents are able to access other smaller areas throughout the facility for reading, meeting with family or friends or privacy, as they choose.  Furniture is appropriate to the setting and residents’ needs. It is arranged in a manner which enables residents to mobilise freely. Interviews with residents and families during the audit indicates satisfaction with the environment and choice of communal areas. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is undertaken on site in a dedicated laundry. Resident’s personal items are laundered on site or by family members if requested. There are two dedicated laundry staff members and the laundry operates seven days a week. One of the two laundry staff was interviewed during the audit and demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen.  There is a designated cleaning team who has received appropriate training. This was confirmed in interview and through sampling of personnel files. Chemicals and cleaning products were stored in lockable cupboards and were in appropriately labelled containers on the cleaners’ trolleys. Cleaning and laundry processes are monitored through the internal audit programme, and the completed audits for 2016 were reviewed.  Family satisfaction survey results in 2016 were positive, with 74% of respondents giving an above average or excellent response for cleaning and 87% giving an above average or excellent response for laundry. Overall 90% of respondents rated the cleanliness of the facility as above average or excellent. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. There is an emergency response plan which has been developed in conjunction with the HBDHB and demonstrates links with the organisation’s other local facility, local civil defence and the DHB. The current fire evacuation plan was approved by the New Zealand Fire Service on the 2008. Currently, trial evacuations are taking place three-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 6 October 2016. The orientation programme includes fire, emergency and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, and gas BBQ, and meet the requirements for the number of residents. There is an emergency 2,000 litre water storage tank located in the facility.  Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff members check the doors during the night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas have opening external windows. Some rooms have doors that open onto small patio areas.  Electric heating provided is provided with either electric wall heaters or electric underfloor heating in all rooms. All bathrooms have a wall mounted electric fan heater.  The building was at a comfortable temperature and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the clinical co-ordinator/infection prevention and control officer (IPC). The infection control programme and manual are reviewed annually.  The clinical coordinator/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the general manager/regional operations manager, facility manager, and tabled at the quality/risk committee meeting. This committee includes the general manager/regional operations manager, clinical quality and compliance manager, facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for six years. She has undertaken IPC training and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The IPC coordinator subscribes to an online NZ professional IPC forum. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  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. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in March 2016 and include appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred two months ago when there was a gastrointestinal (GI) outbreak in the facility and throughout the whole community due to an infected water supply.  Education with residents is generally on a one-to-one basis and has included, reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during the recent GI outbreak. Families confirmed they also were given education by staff during the recent outbreak. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the individual infection register in the resident’s clinical record, infection reporting form, and resident management system. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, facility manager/regional operations manager, clinical quality and compliance manager. Data is benchmarked with other aged care providers within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.  New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff.  A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical coordinator is the restraint coordinator and she provides support and oversight for enabler and restraint management in the facility. At interview she demonstrated a sound understanding of the organisation’s policies, procedures and practice and her role and responsibilities.  On the day of audit six residents were using restraints and three residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. This provides for a robust process which ensures the on-going safety and wellbeing of the resident.  Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and files reviewed of those residents who have approved restraints and from interview with the restraint coordinator. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval group is made up of the restraint coordinator, clinical manager, acting facility manager, and two other RNs. The group meets within the quality / health and safety committee meetings and minutes are maintained. The restraint approval group is responsible for the consideration and approval of the use of restraints and the restraint processes, as defined in policy.  Minutes of the meeting were reviewed, residents’ files reviewed and the restraint coordinator interviewed. It was evident that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. The group has also recently approved a new type of restraint for use – pelvic briefs – in order to provide a safer and more comfortable option. This is being monitored by the approval group to ensure it meets the requirements of organisation’s policy for safety and wellbeing of restraints.  Evidence of family/whānau/enduring power of attorney (EPOA) involvement in the decision making, as is required by the organisation’s policies and procedures, was on file in each case, use of a restraint or an enabler is included in the care planning process and documented in the plan of care. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint were documented and included all requirements of the Standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator’s involvement, and input from the resident’s family/whānau/EPOA.  The restraint coordinator described the documented process. The general practitioner has involvement in the final decision on the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the residents’ safety and security. Completed assessments were sighted in the records of residents who were using a restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as the use of sensor mats, low beds and are explored before use of a restraint is implemented.  When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records contain the necessary details, and care processes ensure dignity and privacy are maintained and respected. This is included in the resident’s care plan and monitoring forms reviewed recorded that this had occurred as required.  A restraint register is maintained. It is updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.  Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraints is to be minimised and how to maintain safe use was confirmed. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Review of residents’ files evidenced the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.  The evaluation includes all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint approval group considers the overall use of restraint on a monthly basis. Meeting minutes record the analysis and evaluation of amount and type of restraint or enabler use in the facility. As noted, there has been a recent addition to the type of restraint used and the efficacy of this new type of restraint is also being tracked at the monthly meetings.  There is an internal audit of restraint / enabler use and the results of this are discussed by the approval group. They utilise the benchmarking data collated by the Anglican Care clinical, quality and compliance manager and also discuss their own findings at the regional quality meetings. This was confirmed through reviewing the minutes of the Waiapu House restraint approval group meetings and the Anglican Care regional quality group meetings. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Negligible | Until two recent resignations there have been four trained RNs completing interRAI assessments with the clinical coordinator as a backup. With these resources the facility remained up to date. Due to staff resignations there are currently only two interRAI trained and competent RNs at Waiapu House. One of these RNs is currently on leave and the remaining RN has only limited time available to undertake these assessments. | On the day of the audit the acting facility and clinical manager reported that they are no longer able to remain up to date with their interRAI assessments. There is tracking and monitoring of the timeliness of interRAI assessments and on the days of the audit there are 20 of 74 overdue which cannot be completed.  Two RN’s are enrolled for training, one in November 2016 and one in February 2017 (although they are waitlisted to attend the November 2016 session as well.) | Ensure that the plan for additional RNs to attend interRAI training is implemented. Continue with tracking and monitoring of interRAI assessments as is currently being done.  180 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There are policies, procedures and a plan of compulsory training to guide the ongoing development of all staff in the facility. In mid-2016 the clinical manager identified that compulsory training had not been occurring as required by the organisation’s policies. She developed a spreadsheet identifying gaps in compulsory training and annual competencies, scheduled training sessions, has followed up on quality improvement trends with information sessions and additional education, and addressed a significant proportion of the deficits. | A documented plan of work to address gaps in compulsory training has been implemented. However approximately one third of staff are yet to complete all compulsory annual training and competencies. | Continue to implement the scheduled training and competency assessments, as planned.  180 days |

# 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.

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End of the report.