

Christchurch Methodist Central Mission

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:

Legal entity:	Christchurch Methodist Central Mission
Premises audited:	Wesley Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 February 2015 End date: 19 February 2015
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	78

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Wesley Rest Home and Hospital is owned and operated by the Christchurch Methodist Central Mission. The home and hospital is certified to provide hospital, medical and rest home level care for up to 92 residents. On the day of the audit there were 78 residents. Residents and families interviewed were very complimentary of care and support provided.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff

The facility manager has been in the role for over 25 years and reports to the Methodist Mission board. The manager is also supported by a quality coordinator, two clinical nurse managers, registered nurses and care staff.

Improvements are required in relation to advanced directives, corrective action plans following audits, pain assessments and identifying risks associated with the use of restraint or enabler.

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.		Some standards applicable to this service partially attained and of low risk.
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The staff at Wesley Rest Home and Hospital ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Wesley Rest Home and Hospital has a quality and risk management system in place that is implemented and monitored. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide

sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The service has adopted InterRAI for its assessments and care planning process. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. Care plans demonstrate service integration. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. Medication policies and procedures are in place to guide practice. Education and medication competencies are completed by all staff responsible for administration of medicines. The activities programme is facilitated by diversional therapists. The activities programme provides varied options and activities are enjoyed by the residents. The programme caters for the individual needs and involves community activity. All food is cooked on site by the in house chef and cooks. All residents' nutritional needs are identified, highlighted and choices available and provided, meals are well presented.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Rooms are individualised and uncluttered. Resident rooms are large enough for rest home and hospital level residents. External areas are safe and well maintained. All building work is safely fenced off and not accessible to residents or visitors. The facility has a van and a car available for transportation of residents. Those transporting residents hold a current first aid certificate. There are lounges in each area. There are adequate toilets and showers for the client group. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has central underfloor heating, wall heaters and wall mounted heaters and temperature is comfortable and constant.

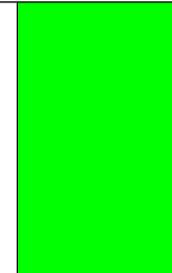
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were fourteen residents requiring restraints and thirteen residents using enablers. The service reviews restraint as part of the quality management and staff are trained in restraint minimisation.

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.



Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

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	46	0	4	0	0	0
Criteria	0	97	0	4	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](#).

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>Discussions with staff (five health care assistants, one diversional therapist, one activities coordinator, five registered nurses, one enrolled nurse, two clinical managers and the nurse manager) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Twelve residents (six rest homes and six hospital) and five relatives (two rest home and three hospitals) were interviewed and confirmed the services being provided are in line with the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Low	<p>Informed consent and advanced directives were recorded as evidenced in the ten resident files reviewed (three rest home, five hospital, one young person with disability and one resident at end of life). Six of ten files were appropriately signed by the resident. Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed.</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>Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.</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 relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the facility.</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>	<p>FA</p>	<p>A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. No complaints were received in 2014. Systems and processes have been in place to ensure that any complaint received is managed and resolved appropriately. Three complaints received in 2015 have all been appropriately managed and resolved. A complaint to the Health and Disability Commissioner has resulted in no further action to be taken by the deputy commissioner, however recommendations were for the service to review the policy and guidelines for falls management and staff training around clinical assessment following incidents to be reviewed (link 1.2.3.). Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well-informed about the code of rights. Resident meetings and a resident and family survey provide the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and are available at reception.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment.</p> <p>Church services are held weekly and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.</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>	FA	<p>The service has a Maori health plan and an individual's values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There are currently no residents at Wesley Rest Home and Hospital who identify as Maori. The service has established links with local Maori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. One staff member who identifies as Maori acts as a liaison and resource for staff and residents.</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>	FA	<p>Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process includes the signing of house rules and a service code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Registered nursing staff have completed training around professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The quality manager is</p>

		<p>responsible for coordinating the internal audit programme. A variety of staff meetings and residents meetings are conducted.</p> <p>Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the nurse manager and clinical managers. Care staff complete competencies relevant to their practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur six monthly and the nurse manager and clinical managers have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available. All residents at the service currently are English speaking.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The Christchurch Methodist Central Mission owns and operates Wesley Rest home and Hospital. The service provides care for up to 92 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 78 residents in total (32 residents at rest home level and 42 residents at hospital level). The manager is a registered nurse who maintains an annual practicing certificate. She is experienced in aged care and has been manager of the service for over 25 years. The manager reports to the chief executive officer of the mission on a variety of management issues. The mission has a strategic plan for 2015-2018 and quality risk management plan that have been implemented. The manager has attended in excess of eight hours of professional development in the past 12 months relating to managing the facility and includes attending aged care conference, attending internal and external meetings, attending two monthly DHB aged care committee meetings and maintaining nursing professional development. The nurse manager has received support from two clinical managers, a quality manager and a household/operations</p>

		<p>supervisor. A new quality manager has been at the service for three weeks. The new quality manager is a registered nurse with an extensive nursing background and for the last five and a half years was the national manager for the implementation and training of InterRAI.</p> <p>The service is in the process of building a new facility to replace the existing building.</p>
<p>Standard 1.2.2: Service Management</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>The quality manager (registered nurse) provides cover during a temporary absence of the nurse manager with support from the two clinical managers and the household/operations supervisor.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>Progress with the quality and risk management programme is monitored through the quality improvement meeting, and the various facility meetings. The 2014 quality objectives were reviewed. Monthly and annual reviews have been completed for all areas of service. Meeting minutes have been maintained and staff were expected to read the minutes and sign off when read. Discussions with registered nurses and health care assistants confirmed their involvement in the quality programme. Resident/relative meetings have been held. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2014 has been completed and a schedule is in place for 2015. Areas of non-compliance identified at audits have been identified for improvement, however not all identified issues have resulted in the development of a corrective action plan to action and resolve issues. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Residents' are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p> <p>Falls prevention strategies are implemented for individual residents.</p>

		<p>Following a complaint to the Health and Disability Commissioner from which the deputy commissioner requested review of policy and guidelines for falls management and that staff training around clinical assessments and procedures be reviewed at this audit the service has completed the following;</p> <p>Falls prevention policy has been reviewed October 2014 and now includes contacting the GP or emergency services if necessary.</p> <p>The resident incident and accident and medication error reporting policy has been reviewed October 2014 and now includes more details around contacting families promptly and this to be noted on the incident and accident form and on the family communication sheet. The policy now also states that if the incident happens between 11pm and 7am and the family have not indicated to be contacted at any time then the morning shift are to contact the family.</p> <p>A new flow chart for the incident and accident process has been implemented which includes follow up by the registered nurse for neurological observations if a head injury is suspected, for possible x-ray to be completed, for the doctor to be notified and for the next of kin to be notified.</p> <p>Training for staff around incident and accident management, changes to policies and documents and leadership has been completed in September, October and December 2014.</p> <p>Staff meetings documents discussion on reviewed and updated policies and documents. All staff have read the complaint and signed they have read the complaint.</p> <p>The quality meeting November 2014 documents all reviewed and updated policies procedures and documents.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for January 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions,</p>

		<p>and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p> <p>The service has met with both families and measures have been implemented to reduce the risk of the resident wandering from the facility. Interventions are documented in the resident care plans. Staff on interview were fully aware of both residents and interventions implemented. One family member on interview reports attending a meeting with the nurse manager to discuss risk management interventions including the requests of the family. The family member is very happy with how the service is managing their relative and reports the family is kept fully informed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates are kept. Eleven staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 30 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Health care assistants are orientated by 'preceptors'. Annual appraisals are conducted for all staff. A completed in-service calendar for 2014 exceeded eight hours annually. There is an in-service calendar for 2015. Health care assistants have completed either the national certificate in care of the elderly or have completed or commenced an aged care education programme. The nurse manager and registered nurses attend external training including conferences, seminars and education sessions with the local DHB.</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>	FA	<p>Wesley Rest Home and Hospital has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There are at least two registered nurses on duty at all times. The full time nurse manager is also a registered nurse. Health care assistants and residents and family interviewed advised that sufficient staff are rostered on for each shift. All registered nurses have been</p>

		trained in first aid and CPR.
<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 files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Information containing sensitive resident information are not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts have been stored in a separate folder.</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>Wesley Rest Home and Hospital have a developed InterRAI assessment process and residents' needs are assessed on entry. The service has a comprehensive admission policy. Residents and/or relatives are provided with information in relation to the service. Information gathered at admission is retained in the residents' records. The residents and family members interviewed stated they were well informed upon admission.</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>There is a transfer plan policy. A record is kept and a copy is kept on the resident's file. This was sighted in two resident files (from the hospital) where the resident had been transferred to hospital acutely. All relevant information is documented and communicated to the receiving health provider or service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive medication policies in place. All medication administering follows safe medication guidelines as set down in the policies. Medication fridge temperatures are monitored weekly. Medication reconciliation is completed on admission and the policy includes guidelines on checking medications on arrival.</p> <p>All staff administering medications have completed an annual medication competency. Staff were observed safely administering medications. At the time of audit there were no residents' who were self-administering medications.</p> <p>Eighteen medication charts were reviewed. All meet legislative</p>

		guidelines and administration charts are documented accurately.
<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>	FA	<p>Wesley Rest Home and Hospital Rest has two large well equipped kitchens. The menus designed by the chef and moderated by a dietitian. There is a summer and winter four week rotational menu. All meals are prepared in the two main kitchens and served from the kitchen directly to the residents' in the main dining room, the 'café' dining rooms and to the two houses. Diets are modified as required. The chef confirmed that there are alternatives available. Any changes to nutritional requirements are communicated to the cook by the registered nurse.</p> <p>Kitchen fridge, freezer and food temperatures are monitored and documented.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</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>	FA	<p>There are records kept of reasons for any declined entry; due to there being no beds available or else the unavailability of required level of care. On interview management were able to discuss the process of declined entry and support and alternatives for those declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>Wesley Rest Home and Hospital have adopted the InterRAI assessment tool as evidenced in resident files sampled. These were reviewed at least six monthly and have been used to assess level of risk and required support. However, residents with chronic pain and prescribed regular analgesia did not all have review and evaluation of pain assessments.</p> <p>All ten resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans demonstrate service integration and demonstrate input from allied health professionals. All short-term and long term care plans reviewed were completed by registered nurses. Care plans reviewed provide evidence of individualised support and include interventions for all assessed needs (link 2.2.3). Resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. Short-term care plans were in use for changes in health status.</p>

		Resident files reviewed identified that family were involved.
<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>	FA	<p>Ten resident files were reviewed, three from rest home, five from hospital, one young person with disability and one palliative. The care plans overall were well documented (link 2.2.3). All residents' interviewed stated their needs were being appropriately met. Dressing supplies are available and a treatment room was stocked for use. Continence products are available and were identified for daytime and night use, plus any other management. Procedures for wound assessments, evaluation and nursing interventions were in place as evidenced in the wound management folder. There were short term care plans in place for acute resident problems.</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>	FA	<p>There is one diversional therapist, one activity co-ordinator and one resident advocate that provide an activities programme over five days each week with separate programmes in the hospital and rest home and some combined activities. The programme is planned monthly and residents receive a personal copy of planned monthly activities. A diversional therapy plan was developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities. The service has a van and a car that is used for resident outings and appointments. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The evaluation and care plan review policy require that long-term care plans are reviewed six monthly, or as residents' condition changes. The care plan evaluations reviewed described progress against set goals and needs identified in the care plan. Short-term were utilised when required. Any changes to the long-term care plan were dated and signed by the registered nurse.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>resident files. Discussions with the clinical managers and registered nurses identified that the service has access to specialist nursing services such as continence nurses, palliative care services and wound specialist nurses.</p>
<p>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.</p>	<p>FA</p>	<p>All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Product use charts were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been completed.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Wesley Rest Home and Hospital provides a clean and safe environment, which is well maintained and appropriate for its purpose. Reactive and preventative maintenance occurs. The building holds a current warrant of fitness that expires 1 January 2016. Electrical equipment is checked annually. The external areas are well maintained and gardens are attractive. There is wheelchair access to all areas. The service has a van and a car used for transporting resident both with current warrant of fitness and registration. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are smaller, quieter lounges for residents and visitors. All required equipment is available. There is currently building work being completed, which is safely fenced off to prevent access by residents, staff and visitors. The outside area for residents is well designed and appropriate for residents who like to go outside.</p>
<p>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.</p>	<p>FA</p>	<p>The hospital and rest home included sufficient toilets and showers for the resident population. There is also adequate toilet facilities for use by staff and visitors. Communal toilets and bathrooms have appropriate signage and shower curtains installed.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas</p>	<p>FA</p>	<p>The rooms are spacious and it can be demonstrated that wheel chairs, hoists and the like, can be manoeuvred around the bed and personal space, for those indicated. Caregivers interviewed report that rooms</p>

appropriate to the consumer group and setting.		have sufficient room to allow care to take place. Residents interviewed voiced their satisfaction for the size of their bedrooms.
<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	There is a lounge and separate dining rooms in the hospital building, the rest home/hospital apartments and both houses. All lounge/dining rooms are also accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture is well arranged to facilitate this.
<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	All laundry is done on site and there are dedicated laundry and cleaning staff. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer's labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. Residents interviewed confirmed that the facility was kept clean.
<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>	FA	The service has a fire and emergency procedures manual. The fire evacuation scheme was approved in 1985 with updates in 1997 and 1999. There is a staff member with a first aid certificate on each shift. Fire safety training has been provided. A call bell light over each door and a panel in each corridor alerts staff to the area in which residents require assistance. Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. Civil defence and first aid resources were available. Sufficient water is stored for emergency use and alternative heating and cooking facilities are available. Emergency lighting is installed. Security checks have been conducted each night by staff and a contracted firm.
<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>	FA	The facility has a mix of underfloor heating, heat pumps and wall mounted heaters which can be controlled in each area/room; rooms are well ventilated and light. Facility temperatures are monitored monthly. There is plenty of natural light in resident's rooms.
<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 appropriate to the size and scope of the service.</p>	FA	Wesley Rest Home and Hospital has an established infection control (IC) programme. The infection control programme has been appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. A registered nurse is the designated infection control nurse with support

		from the nurse manager, quality manager, clinical managers and the quality team. The IC/quality team meets to review infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.
<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	There are adequate resources to implement the infection control programme at Wesley Rest Home and Hospital. The infection control (IC) nurse has maintained her practice by attending infection control updates. The IC nurse reports to the quality team which is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<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	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly.
<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	The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control nurse with support from the nurse manager, quality coordinator and clinical managers. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and were advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that was appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014 and is scheduled for 2015.
<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</p>	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and

infection control programme.		symptoms of infection. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly facility infection summary and staff were informed. The data has been monitored and evaluated monthly. A norovirus outbreak in January 2014 (affecting 13 residents and seven staff) was appropriately managed, with notification to the relevant authority.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation is overseen by restraint coordinators who are the clinical managers. There were 13 hospital residents and one young person with disability on restraint. Restraints used included bedrails and lap belts. Eleven hospital residents were using bedrails and/or lap belts as enablers. Two rest home residents were using bedrails as an enabler. The use of enablers is voluntary, requested by the resident. A full restraint assessment is completed prior to implementing the enablers. There is evidence of the residents consenting to the enabler.
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 coordinators are the two clinical managers (registered nurse). Assessment and approval process for a restraint intervention included the restraint coordinator, registered nurse, resident/or representative and medical practitioner.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinators, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the eight files reviewed (four restraint and four enablers), assessments and consents were fully completed. Consent for the use of restraint was completed with family/whanau involvement and a specific consent for enabler / restraint form was used to document approval.
Standard 2.2.3: Safe Restraint Use	PA Low	The restraint minimisation manual identified that restraint is only put in place where it was clinically indicated and justified and approval

<p>Services use restraint safely</p>		<p>processes. There is an assessment form/process that was completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan interventions documented however the risks associated with the use of restraint was not documented in the four restraint files reviewed. One resident was using two forms of restraint, however only one restraint was documented in the care plan. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. Eight files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. The service has a restraint and enablers register which is up dated each month.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the restraint co-ordinators at the quality meeting and at the three monthly restraint meeting. Evaluation timeframes are determined by risk levels but at least every three months. The evaluations have been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified by the restraint co-ordinators. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly meetings. There are three monthly restraint meetings held.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.2</p> <p>Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.</p>	PA Low	Advanced directives were recorded in the ten resident files reviewed. Six advanced directives were appropriately signed by the resident.	Four files reviewed had advanced directive recorded but these were signed by the residents enduring power of attorney (EPOA) and not the resident.	<p>Ensure that advanced directives are signed by the resident.</p> <p>90 days</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>	PA Low	The internal audit schedule for 2014 has been completed and a schedule is in place for 2015. Areas of non-compliance identified at audits or from other quality data have been identified for improvement and corrective action plans developed as evidenced in but not limited to areas from cleaning and temperature audit checks.	Health records and clinical file audits have been completed monthly with issues identified as requiring improvement. There has been no corrective action plans developed and therefore no documented evidence that the issues have been addressed and resolved. The service also noted medication errors in October,	<p>Ensure that all areas for improvement following audits have a corrective action plan completed so as to ensure areas for improvement are addressed and resolved. Ensure audits are completed of medication</p>

			November and December 2014. There was no corrective action plan and no audit of the medication charts completed.	charts. 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	There is a comprehensive InterRAI assessment process for all residents which is reflected in the care plans and guides the level of care required.	Two residents files reviewed identified residents with controlled drug medication for pain. These residents did not have ongoing pain assessments' to monitor the effectiveness of analgesia. On review of the medication register, seven residents prescribed regular analgesia did not have review of pain assessments and evaluations.	To ensure all residents identified with pain have completed up to date pain assessments and evaluations. 90 days
Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any	PA Low	Restraint is only put in place where it was clinically indicated and justified and approval processes. There is an assessment form/process that was completed for all restraints and enablers. Eight files reviewed had a completed assessment form and seven of eight files reviewed had care plan interventions documented for each restraint and enabler. Staff interviewed were fully aware of residents using restraint and enablers.	Four restraint files reviewed did not have the risks of using restraint documented in the residents care plan. One resident was using bedrails and a lap belt as restraint with appropriate assessments and consent for both; however, interventions in the residents care plan documented lap belt only. Monitoring had been completed for both lap belt and bedrails therefore the risk has been identified as low.	Ensure that all residents using restraint have risks associated with using restraint documented in the residents care plan. Ensure that all restraints used are documented in the resident care plan. 60 days

<p>advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.</p>				
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.