

# Wharekaka Trust Board Incorporated - Wharekaka Rest Home

---

## 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 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](#).

The specifics of this audit included:

|   |  |
|---|--|
| <b>Legal entity:</b>  | Wharekaka Trust Board Incorporated                   |
| <b>Premises audited:</b>  | Wharekaka Rest Home                                  |
| <b>Services audited:</b>  | Rest home care (excluding dementia care)             |
| <b>Dates of audit:</b>  | Start date: 12 April 2016    End date: 12 April 2016 |
| <b>Proposed changes to current services (if any):</b>   | None   |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 13   |

# 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

Wharekaka Rest Home provides residential care for up to 19 residents who require rest home care. The facility is operated by Wharekaka Trust Board Incorporated.

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

There are two areas requiring improvement relating to infection prevention and control documentation and corrective actions plans following deficits identified at staff and resident meetings.

## Consumer rights

|  |  |  |
|--|--|--|
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |
|--|--|--|

Wharekaka Rest Home provides services that respect the independence, personal privacy, individual needs and dignity of residents. Staff receive regular and ongoing training on resident rights and how these should be implemented in their day-to-day work with residents. During the audit visit, residents were observed being treated in a respectful and professional manner.

Services provided to residents are of an appropriate standard and residents and their families expressed their satisfaction with these services. Policies are in place to ensure residents are free from discrimination or abuse/neglect, with these policies well understood by staff.

The general manager is responsible for the management of complaints. 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. |
|---|--|---|

Wharekaka Trust Board Incorporated is the governing body and is responsible for the service provided. A strategic plan, quality improvement and risk management plan as well as a philosophy of care and core values for the service are in place. There are systems for monitoring the service. The general manager is non-clinical and is supported by a clinical nurse manager. Support is also provided by members of the trust board.

Quality and risk management systems are in place. There is an internal audit programme. Risks are identified. Adverse events are documented on accident/incident forms. Internal audits and accident/incident forms evidenced corrective action plans are being developed, implemented, monitored and signed off. Staff meetings are held and there is reporting of clinical indicators, quality and risk issues and discussion of any trends. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resource management and current annual practising certificates for health professionals who require them. An in-service education programme is implemented. Human resource processes are followed.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice.

The privacy and security of resident information is maintained and resident records are integrated.

## Continuum of service delivery

|  |  |  |
|--|--|--|
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |
|--|--|--|

Detailed and individualised care plans are available to guide care delivery for residents. The care plans reflect a comprehensive assessment process, the integration of a range of clinical information, and the input of residents and families. Care plans are developed, evaluated and updated within appropriate timeframes.

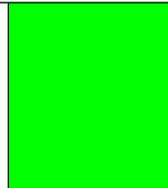
The clinical nurse manager, an experienced registered nurse, is on site each week day. A registered nurse is always available on call outside of those hours. There are well-developed processes in place to ensure continuity of care, such as the updating of resident progress notes each shift, written communication sheets and verbal handovers.

The service has an approved food plan in place and all aspects of food services were organised and well-managed. The residents' dining room is spacious and well-lit and offers a comfortable dining environment for residents. Residents reported their enjoyment of meals and how their individual food preferences were accommodated.

All aspects of medication management are consistent with legislative requirements and best practice. Medications are administered by qualified nurses and senior care givers, all of whom have been assessed as medication-competent.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

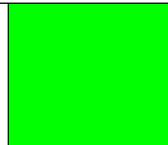
All residents' bedrooms provide single accommodation and there are some rooms with ensuites. Residents' rooms have adequate personal space provided. A lounge, dining areas and alcoves are available. External areas are available for sitting and shading is provided.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site and cleaning and laundry systems, including appropriate monitoring systems to evaluate the effectiveness of these services.

## 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.



Standards applicable to this service fully attained.

The service has policies and procedures which meet the requirements of the restraint minimisation and safe practice standard. There are currently no residents using resident or enablers. There are established systems and practices. Staff education and competency occurs annually. The restraint register is current.

## Infection prevention and control

|  |  |  |
|--|--|--|
| <p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p> |  | <p>Some standards applicable to this service partially attained and of low risk.</p> |
|--|--|--|

The service has a range of infection prevention and control systems in place. This includes including regular staff education, ensuring that personal protective equipment is freely available to staff. Systems are in place to manage infection outbreaks. The infection control coordinator is a senior caregiver, who is supported in that role by the clinical nurse manager. The formalisation of organisational accountability for infection control and the development of a formal infection control programme are areas for improvement.

## Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 43                  | 0  | 2                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 90                  | 0  | 3                                    | 0  | 0                                      | 0  |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 0  | 0                            | 0                                      | 0                              | 0                                      |

# Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome   | Attainment Rating | Audit Evidence  |
|---|-------------------|---|
| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>  | FA                | <p>The orientation of all new staff includes education related to the Health and Disability Commissioner’s Code of Health and Disability Services Consumer’s Rights (the Code), which was confirmed in staff interviews. Annual education on the Code is also provided to all staff, as sighted in staff education records.</p> <p>When interviewed, staff were able to demonstrate their understanding of the Code and could describe examples of how this was incorporated into their daily practice.</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> | FA                | <p>Residents and family members spoken with reported they were consistently given the opportunity to make informed choices and that their consent was obtained and respected. Family members reported they were kept well informed about what was happening with the resident and consulted in situations when clinical decisions needed to be made, such as whether to transfer the resident to hospital.</p> <p>The admission documentation completed by each new resident and/or their family member identified inclusions and exclusions in service. All resident files reviewed contained completed admission agreements. Completed consent forms were also sighted in these files, relating to a range of consents such as medical treatments, outings, and the collection of</p> |

|  |    |   |
|--|----|---|
|  |    | <p>information. Consent is reviewed on an as-required basis, such as when a resident's needs change, or additional medical/surgical treatment is required.</p> <p>A range of policy documents guide staff on the consent processes, including a Treatment Consent policy, Resuscitation protocol and policy, and Advance Directive consent. The CNM reported that the service is currently working with the practice nurse on a project related to advance care planning, with two staff currently completing advance care plan training. There are currently no residents with advance directives, but the CNM advised these would be respected.</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>       | FA | <p>As part of the admission process all residents are given information on the Nationwide Health and Disability Advocacy Service (Advocacy Service), and information on this service is also displayed at reception. An independent advocate runs the monthly resident meetings and is also available as required. The CNM also advised members of the Wharekaka Trust Board play an important role in advocating for residents. Residents and family members confirmed on interview their awareness of how and where to access advocacy support should they require this.</p> <p>Information on the Advocacy Service is included in the staff orientation programme and in the ongoing education programme for staff, as confirmed in training records. Those staff interviewed demonstrated their understanding of advocacy and support services for residents.</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> | FA | <p>Visitors are welcome at Wharekaka Rest Home which has unrestricted visiting hours. All family members spoken with confirmed they felt welcome when they visited, felt involved in resident-related decision and were promptly informed of any resident changes.</p> <p>The activities programme includes participation in a number of community events. Four residents are well enough to walk into the nearby town and a number of residents go out with their families, including overnight stays. The activities programme includes regular van outings, although the activities coordinator advised the van is currently undergoing repairs. The Wharekaka Auxiliary also organise resident outings each month, host special events such as a mid-winter Christmas dinner and are also available for one-on-one support for residents. Residents are also supported to access health care services outside of the facility, such as visits to the dentist.</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>The general manager is responsible for complaints and there are systems in place to manage the complaints processes. A complaints register is maintained. There is evidence that complaints are managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and displayed. Review of the quality and staff meeting minutes provided evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via staff meetings.</p> <p>There have been no investigations by the Health and Disability Commissioner (HDC), Ministry of Health, the Accident Compensation Corporation (ACC), Police or Coroner since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>  | <p>FA</p> | <p>As part of the admission process, every new resident and their family are provided with a copy of the Code and information on the Nationwide Health and Disability Advocacy Service (Advocacy Service). The clinical nurse manager (CNM) discusses this with them at the time of admission and answers any questions they may have. The CNM advised that as residents are often overwhelmed at the time of admission she also discusses the Code with residents again a few days later. Posters on the Code and information on the Advocacy Service are prominently displayed in the facility.</p> <p>On interview all residents and family members confirmed their understanding of resident rights, that they had been given information about the Advocacy Service and any questions they had about this had been answered promptly by staff.</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> | <p>FA</p> | <p>Privacy of resident information was maintained. All residents' clinical files were kept in the nurses' office, which was observed to be locked when staff were not present, and handovers were undertaken in a manner that maintained privacy of information. Electronic records related to residents were password-protected and archived records were securely stored.</p> <p>During the audit visit, staff were observed to address residents by their preferred name, to knock on closed doors before entering a resident's room and to ensure personal privacy of residents during care delivery. Staff were also observed to interact with residents in a friendly, encouraging and unhurried manner. Residents and families reported they were treated</p>   |

|  |    |  |
|--|----|--|
|  |    | <p>respectfully and individual needs were met. All residents have a private room and are encouraged to personalise those rooms.</p> <p>Each resident's individual cultural, religious and social needs, values and beliefs are identified, documented and incorporated into their care plan, which is developed in conjunction with the resident and/or their family. There is a strong emphasis in the care plans on resident abilities and strategies to maximise their independence.</p> <p>The service's policy related to abuse and neglect was well understood by those staff interviewed and there is annual training on elder abuse (confirmed in training records). Staff were able to provide examples of what would constitute abuse and neglect and the actions they would take if they suspected this. All staff undergo a police check as part of the employment process and staff human resource records confirmed those checks had been completed.</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 policy and a Cultural Safety policy which include information to guide staff in meeting the needs of residents who identify as Maori. Two staff members identify as Maori and there are well-established links with the local iwi should any support or advice be required. Additional support is also available through the Wairarapa District Health Board. The Tikanga Best Practice resource is also available for staff.</p> <p>Cultural beliefs and related requirements are incorporated into the resident's admission profile, which then informs the relevant section of the care plan. The CNM advised that deceased residents' rooms are always blessed by a lay preacher prior to the next resident being admitted. If a new Maori resident wished to have an additional Maori blessing of their room this would be arranged.</p> <p>The family member of a resident who identifies as Maori expressed their satisfaction with the services being provided to that resident.</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>The Cultural Safety policy includes guidance for staff in providing safe services for all residents. All care plans reviewed had been individualised to include the personal preferences and special requirements of residents, with detailed interventions listed to ensure these were met. Each of those care plans contained evidence of resident/family involvement in the care plan development.</p> <p>Residents and family members confirmed they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an</p>   |

|   |    |  |
|---|----|--|
|   |    | ongoing basis. They also confirmed that individual values and beliefs were respected.  |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>              | FA | <p>All residents and family members interviewed during the audit visit stated that residents were free from any type of discrimination or exploitation.</p> <p>The orientation programme for new staff includes education related to all forms of discrimination and exploitation, with ongoing annual education on this topic, as confirmed in staff training records. A range of policies and documents, such as the Staff Code of Conduct and House Rules, are also available to guide staff. Staff were able to demonstrate a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> <p>On interview, the doctor confirmed their satisfaction with the standards of service provision and confidence that residents are not discriminated against in any manner.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>  | FA | <p>The service uses a range of clinical policies sourced from an external provider. These policies and protocols are current, reflect best practice and are used to guide care delivery. In addition, the service has well-established and extensive professional networks which support the maintenance of appropriate practice standards. These include regular consultations with a range of specialist staff, such as nurse specialists in areas such as wound care and dementia, hospice, physiotherapist, practice nurses, dietician, and district nurses.</p> <p>On interview, the doctor confirmed their satisfaction with the standard of care provided to residents.</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>All family members interviewed stated they were informed in a timely manner about any changes to the resident's status. There was also evidence of resident/family input into the care planning process.</p> <p>The resident files reviewed all included evidence of open disclosure and effective communication with residents/families. Communication was documented in the whanau record, on the accident/incident form and in the residents' progress notes.</p> <p>The CNM advised that interpreter services could be accessed from the Wairarapa DHB when required.</p>   |

|  |               |  |
|--|---------------|--|
|  |               |  |
| <p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>   | <p>FA</p>     | <p>Wharekaka Trust Board Incorporated is the governing body and is responsible for the services provided at Wharekaka Rest Home. The current strategic plan includes a philosophy, mission statement, vision, purpose and objectives.</p> <p>Systems are in place for monitoring the services provided including regular monthly reporting by the general manager (GM) and clinical nurse manager (CNM). One report is then presented by the GM to the trust board. Trust board members stated they meet weekly on site with the GM to discuss any matters that may arise.</p> <p>The facility is managed by a suitably qualified and experienced manager who has been in this position for four years. The GM is non-clinical and is supported by a CNM. The clinical nurse manager is a registered nurse (RN) who has experience in working in the aged care sector. The managers are supported by the trust board.</p> <p>Wharekaka Rest Home is certified to provide rest home care. On the day of this audit there were 13 rest home level care residents.</p> <p>Wharekaka Rest Home has a contract with the district health board (DHB) to provide aged related residential care.</p> <p>Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.</p> |
| <p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | <p>FA</p>     | <p>In the absence of the general manager, the clinical nurse manager deputises. When the clinical nurse manager is absent, the other registered nurse deputises. The general manager and the clinical nurse manager confirmed their responsibility and authority for these roles.</p>  |
| <p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>  | <p>PA Low</p> | <p>The quality improvement and risk management plan is used to guide the quality programme and includes quality goals and objectives. There was evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. There is an internal audit programme and completed internal audits for 2015 and 2016 were reviewed. Quality improvement data is being reported to the trust board and to staff via staff meetings.</p>  |

|   |           |   |
|---|-----------|---|
| <p>continuous quality improvement principles.</p>   |           | <p>Staff and quality meetings are held. There was evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. However, meeting minutes did not evidence corrective actions were developed and implemented as required.</p> <p>Staff reported they are kept informed of quality and risk management issues, including clinical indicators. Copies of meeting minutes and graphs of clinical indicators were available for staff to review.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice and reference legislative requirements. Policies, procedures and forms are reviewed and updated and are current. Care staff confirmed the policies and procedures provide appropriate guidance and that they are advised of new and revised policies.</p> <p>Actual and potential risks are identified and documented in the hazard register. The hazard register identifies all known hazards and shows the actions put in place to minimise, isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood and implemented documented hazard identification processes. The health and safety coordinator has recently completed ongoing education relating to their role.</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>Staff are documenting adverse, unplanned or untoward events on an incident/accident form and data is collated each month. The original is filed in residents' files. Data includes summaries and graphs of various clinical indicators. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Resident's files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Family confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff stated they are made aware of their essential notification responsibilities through: job descriptions; policies and procedures; and professional codes of conduct. Review of staff files and other documentation confirmed this. Policy and procedures comply with essential notification reporting. There has been one essential notification since the last audit and the GM confirmed this. Staff confirmed they are aware of reporting requirements.</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> | <p>FA</p> | <p>There are policies and procedures relating to human resource management. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientation, competency assessments and police vetting.</p> <p>The CNM is responsible for managing the in-service education programme and there was evidence indicating in-service education is provided for staff utilising various methods of delivery. Individual records of education are maintained as are competency assessments. Education records for each session and in-service education programmes indicated good attendance at education sessions.</p> <p>Care staff are encouraged to complete a New Zealand Qualification Authority education programme. There is an external assessor for the programme.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.</p> <p>Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.</p> <p>Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>       | <p>FA</p> | <p>There is a documented rationale for determining staffing levels and skill mixes that is based on best practice. The minimum number of staff is provided during the night shift and consists of one caregiver. Several staff members live close to the facility and are available should they be required. The GM and the CNM are also on-call after hours. Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and family reported there were enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.</p>   |
| <p>Standard 1.2.9: Consumer Information</p>   | <p>FA</p> | <p>All components of the resident records reviewed included the resident's unique identifier. The</p>  |

|   |    |  |
|---|----|--|
| <p>Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>   |    | <p>clinical records were well-organised and integrated, including information such as medical notes, reports from other health professionals and laboratory results. Detailed resident progress notes were completed every shift, detailing resident response to service provision and progress towards identified goals. Sample signatures for all staff making entries into the progress notes were included in all clinical files reviewed.</p> <p>Resident-related information is kept in both hard-copy and electronic files. These files were maintained securely. Electronic files were password protected and can only be accessed by designated staff. Hard copy information, such as clinical files, is kept in the nurses' station, which was observed to be kept locked when no staff were present. Archived material was also kept securely but was easily retrievable.</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>The CNM described the processes associated with admission to the services. Residents can only be admitted when their level of required care has been assessed and confirmed by the Needs Assessment and Service Coordination Service (Focus).</p> <p>Prospective residents are provided with a comprehensive information pack related to the service and the admission criteria and processes that must be completed prior to admission are discussed with them. Prospective residents and their family/whanau are encouraged to visit the facility prior to admission. Family members interviewed confirmed they were satisfied with the information made available to them as part of the admission process.</p>  |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>                            | FA | <p>The service used the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. The CNM advised that when a resident is transferred to another service, a range of information is provided to that service, including documentation related to the resident's abilities and the reason for transfer. Copies of this information were sighted in several clinical records.</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>All aspects of medication management comply with legislative requirements and safe practice guidelines.</p> <p>All staff who administer medication in the facility have current medication competency assessments, of which records were sighted. Medications were charted in an appropriate manner, using an electronic medication system. Medications were reviewed at least three monthly and medication administration records reviewed were complete. An observation of a</p>  |

|   |    |  |
|---|----|--|
|   |    | <p>medication round confirmed that medications were administered in a safe and appropriate manner.</p> <p>Medications are supplied to the facility using the robotics medication pack system. Evidence was sighted that these packs are checked against the medication chart by a RN on arrival to the service. Surplus and expired medication is returned to the pharmacy. The date of first use of eye drops was recorded on those products currently in use. A stocktake of all controlled medication is undertaken weekly. The medication fridge temperature is checked at least three times weekly and these records were sighted.</p> <p>The service does not use medication standing orders. Processes are in place for residents to self-medicate, should this be required, although no residents were currently self-medicating.</p>  |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>All aspects of food service management comply with legislative requirements and best practice.</p> <p>The service has an approved food plan, dated 16 February 2016, (approval sighted). The kitchen was organised, well maintained and clean. Staff are appropriately qualified for their roles.</p> <p>The kitchen can cater for a range of nutritional requirements, including diabetic, vegetarian, gluten-free and soft diets. A six-weekly menu, with summer and winter options, was last reviewed by a registered dietician in January 2015. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs are recorded on the kitchen whiteboard. Residents are weighed monthly and nutritional supplements administered as prescribed. Specialised crockery, such as lip plate and feeding cups, are available. There is a spacious, well-lit dining room for residents, or they may have meals in their own room if they wish.</p> <p>Staff monitor resident satisfaction with food services by monitoring wastage, resident meetings, informal feedback and annual satisfaction surveys. Residents spoke of their enjoyment of meals, and how their individual preferences were accommodated.</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</p>   | FA | <p>If a prospective resident did not meet the entry criteria, or there were no vacancies at that time, the CNM advised that she would support them and their family to contact Focus to find an appropriate placement.</p>   |

|   |    |   |
|---|----|---|
| consumer and/or their family/whānau is managed by the organisation, where appropriate.  |    |   |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>  | FA | Residents are assessed by a registered nurse within 24 hours of admission. An initial assessment and care plan is completed, which also incorporates information provided by the resident/family, the NASC assessment, and other information such as hospital discharge summaries. Within three weeks of admission the interRAI assessment is completed and a long term care plan developed in consultation with the resident and their family. All resident records reviewed included evidence of required timeframes being met and of resident/family involvement.  |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>  | FA | All resident records reviewed included a detailed, comprehensive and individualised care plan which provides guidance for care delivery staff to meet the resident's identified needs. Plans reflected the support needs of residents, and the outcomes of the integrated assessment process. Residents and families stated they felt included in the development of these plans and their ongoing evaluation.  |
| <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 | Registered nurses are available 24 hours a day to provide support and guidance for care delivery staff. There was evidence in all resident records reviewed of regular, timely and comprehensive assessment of needs which then informed the care plan and the provision of care services. Staff also had access to a range of clinical policies which reflect best practice and are an additional source of information for staff. The doctor expressed satisfaction with the provision of services to residents.  |
| <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>An experienced activities coordinator is temporarily coordinating the activities programme. A qualified diversional therapist has been employed and was due to start within a few days of the audit visit. The activities coordinator is on site for 25 hours a week and there is also regular input from volunteers, such as the Trust Auxiliary.</p> <p>Residents' previous and current interests are assessed on admission and individual activity plans completed within three weeks and reviewed six monthly. This was confirmed in resident records. These plans help inform the development of the varied and interesting monthly activity programme. Activities held over the last month included exercises, games, poems,</p> |

|   |    |  |
|---|----|--|
|   |    | <p>housie, movies, a picnic club, current events, knitting circle, reminiscence, crafts, current events and entertainment. A church service is held monthly. Activities are provided both in a group and one-on-one basis. The service does have a mobility van, although this is currently out of service for repair.</p> <p>All residents spoken with advised they enjoyed the activities programme and commented on the variety of activities available.</p>  |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | FA | <p>All care plans reviewed had been evaluated at least six monthly and more frequently if clinically indicated. Evaluations were undertaken by registered nurses and detailed the resident's progress towards achieving their identified goals. Clinical reassessments were also undertaken as part of the evaluation process. Short term care plans were developed when residents' needs changed and these plans were also reviewed in a timely manner. When progress was different from expected, care plans were updated accordingly.</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 disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>The right of residents to access other health and/or disability providers is maintained. Support is available to transport and accompany residents to external health-related visits, as confirmed in interviews with staff and residents. When the need for other services is identified, the doctor or a registered nurse sends a referral to seek specialist provider assistance. Copies of referrals were sighted in clinical records. The resident/family confirmed on interview that they are kept informed about the referral processes.</p>   |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>                      | FA | <p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff have received education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There was provision and availability of protective clothing and equipment that is appropriate to the recognised risks. Protective clothing and equipment was observed in the sluice/laundry. Staff were observed using the protective clothing provided.</p> |

|   |           |   |
|---|-----------|---|
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>  | <p>FA</p> | <p>A current building warrant of fitness is displayed. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme in place and buildings, plant and equipment are maintained to an adequate standard. Maintenance is undertaken by an external contractor. Documentation evidenced testing and tagging of equipment and calibration of biomedical equipment is current.</p> <p>There are external areas available that are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are appropriately actioned. Residents also confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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>Some rooms have an ensuite. There are adequate numbers of communal bathrooms and toilets throughout the facility. Residents reported that there are sufficient toilets and they are easy to access. Appropriate signage and privacy locks were observed on toilet and bathroom doors.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote resident independence.</p>  |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>   | <p>FA</p> | <p>There is adequate personal space provided for residents and staff to move around within the bedrooms safely. All bedrooms provide single accommodation. Residents spoke positively about their accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheel chairs.</p>   |
| <p>Standard 1.4.5: Communal Areas For</p>   | <p>FA</p> | <p>There are a number of areas for residents to frequent for activities, dining and relaxing and</p>  |

|  |           |  |
|--|-----------|--|
| <p>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>                              |           | <p>these are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>   |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>               | <p>FA</p> | <p>All laundry is washed on site. Residents and family reported the laundry is managed well and residents' clothes are returned in a timely manner. The resident/family survey confirmed this. Care staff are responsible for the laundry and they demonstrated knowledge of the laundry processes.</p> <p>There is a dedicated cleaner on site who has received appropriate education. Interview of the cleaner and training records confirmed this. The cleaner has a lockable cupboard to store chemicals. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>  | <p>FA</p> | <p>There is an approved fire evacuation scheme. An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly and is current. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures.</p> <p>There is always at least one staff member on duty with a current first aid certificate.</p> <p>All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas barbecues.</p>              |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | <p>FA</p> | <p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by hot water heaters. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area. All resident areas are provided with natural light.</p>  |

|   |               |  |
|---|---------------|--|
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | <p>PA Low</p> | <p>The service uses an infection control manual developed by an external provider. The manual includes definitions, procedures, guidelines to identify infections, information for employees related to accidents, spills, needle stick injury prevention, sharps management and single-use items. There is little documentation to indicate how the resource manual is to be implemented by the service. Although practices are in place to minimise infection, such as the reporting of infections to the general manager and the collation of surveillance results, these practices have not been documented into a formal infection management plan. A recent infection outbreak, involving a number of residents and staff, was handled efficiently and effectively (details sighted).</p> <p>A senior care giver is the designated infection control coordinator. Infection control matters, including surveillance results, are reported to the CNM and the general manager. Infection rates are reported at staff meetings, as seen in minutes.</p> <p>A sign at the main entrance to the facility asks anyone who is or has been unwell in the past 48 hours to not 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.</p> |
| <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>                   | <p>FA</p>     | <p>The infection control coordinator is a senior caregiver, who has been in the role for some years, and has completed a variety of education related to infection control, as confirmed in training records. The coordinator works in consultation with the CNM, an experienced registered nurse. The CNM has access to diagnostic results to ensure timely treatment and resolution of infections. The service is also able to access established networks for additional infection control support, such as the Infection Control Team at the Wairarapa DHB or the public health unit. The general manager and CNM advised that they will be reviewing the infection control coordinator position in the near future and it is likely that this position will be held by a registered nurse.</p> <p>Protective equipment is freely available to staff, who confirmed the availability of this equipment. The service also maintains a supply of additional equipment in case of an infection outbreak (supplies sighted). The quantity and range of these supplies were analysed following a recent infection outbreak and additional supplies were obtained.</p>   |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect</p>  | <p>FA</p>     | <p>A comprehensive policy/procedure manual, produced by an external provider, guides infection prevention and control practices. This complies with relevant legislation and current accepted good practices. The manual is reviewed annually, with the last review being</p>  |

|  |           |  |
|--|-----------|--|
| <p>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> |           | <p>undertaken in 2015.</p> <p>Housekeeping and kitchen staff were observed to be compliant with generalised infection control practices. Care delivery staff were observed using hand sanitisers on a regular basis and wearing disposable aprons and gloves as appropriate.</p>   |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>  | <p>FA</p> | <p>Infection control is a component of the staff orientation programme. Annual infection prevention and control education was provided to staff, as confirmed in staff training records and the annual education plan.</p> <p>This education is provided by the infection control coordinator and qualified nursing staff, as well as the infection control nurse from the DHB. The CNM advised that additional staff education is also provided on an as-required basis, such as if there is an increase in specific infections.</p> <p>Education with residents is generally on a one-to-one basis. This may include reminders about handwashing or strategies to minimise the possibility of infections such as urinary tract infections.</p>   |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>  | <p>FA</p> | <p>The service has not identified which infections will be part of its infection surveillance programme. The infection control coordinator advised that when the doctor confirms an infection, this is documented on a surveillance sheet. This surveillance data is collated by the general manager, graphed for that month, and reported at the monthly staff meetings. The total number of infections is collated on an annual basis (reports sighted) but there was no evidence of surveillance data being analysed for trends. The service does not use internal benchmarking.</p> <p>Documentation related to a recent gastro-intestinal outbreak was detailed and consistent with best practice. There was also evidence of analysis of that data and of a quality initiative being implemented to address an area which the CNM thought could have been improved in relation to the outbreak management. Refer also to criteria 3.1.1 and 3.1.3.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>   | <p>FA</p> | <p>There were no residents using restraints or enablers. There is a restraint register should restraint be used. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers. Restraint is an agenda item at the monthly staff meetings. The restraint coordinator was knowledgeable concerning</p>   |

|  |  |                      |
|--|--|----------------------|
|  |  | restraint processes. |
|--|--|----------------------|

## Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome  | Attainment Rating | Audit Evidence  | Audit Finding   | Corrective action required and timeframe for completion (days)   |
|---|-------------------|---|---|--|
| <p>Criterion 1.2.3.8</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            | <p>Corrective action plans are developed and implemented following deficits identified in internal audits, incident and accident reporting and health and safety. However, staff and resident meeting minutes do not evidence corrective action plans, timeframes for completion, close out date and sign off. Deficits identified are not always brought forward to the following meetings and reported back to staff and residents.</p> | <p>Staff and resident meeting minutes do not evidence corrective action plans, timeframes for the action to be completed, date of close out and sign off.</p> | <p>Provide evidence that staff and resident meeting minutes evidence corrective action plans, timeframes for the action to be completed, date of close out and sign off following deficits identified.</p> <p>180 days</p> |
| <p>Criterion 3.1.1</p> <p>The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in</p>                | PA Low            | <p>The infection control coordinator has a job description, but no documentation was sighted for organisational accountability for infection control or how this was reported to senior management and the Trust Board. Terms of reference have been developed for an infection control committee, but the membership of the</p>  | <p>Although there is a job description for the infection control coordinator, the lines of accountability with the organisation for infection control,</p>    | <p>The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation</p>   |

|   |        |   |  |  |
|---|--------|---|--|--|
| the organisation leading to the governing body and/or senior management.  |        | committee is not stated.  | including reporting, are not clearly documented.   | leading to the governing body and/or senior management.<br><br>180 days  |
| <p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p> | PA Low | The organisation has a comprehensive infection control resource manual, supplied by an external provider. The organisation does not currently have documentation that details how that infection control manual is to be implemented by the service. For example, there is no documentation related to which infections will be reported as part of the surveillance programme. | The organisation has a very brief infection control programme that provides insufficient detail of how the externally-produced infection control manual is to be implemented by the service. | <p>There is a clearly defined and documented infection control programme that is reviewed at least annually.</p> <p>180 days</p> |

## 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.