

Christchurch Methodist Central Mission

Introduction

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

The audit has been conducted by 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: 16 September 2016 End date: 16 September 2016
Proposed changes to current services (if any):	A partial provisional audit was also conducted to assess the new hospital building. Residents have been accommodated in the new facility since July 2015.
Total beds occupied across all premises included in the audit on the first day of the audit:	79

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

WesleyCare 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 88 residents. On the day of the audit, there were 79 residents.

Residents and families interviewed were complimentary of care and support provided. Staff turnover remains low. The manager is also supported by a deputy manager, two clinical nurse managers, registered nurses and care staff.

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

A partial provisional audit was also conducted to assess the new hospital building. The service has utilised the new building since July 2015. The service has addressed one of four findings from the previous audit relating to identifying risks associated with the use of restraint or enablers. Further improvements are required around advanced directives, corrective action plans, and assessments.

The surveillance audit has identified that improvements are required around reporting of adverse events, care plan interventions, medication management, and residents who self-administer medications.

The partial provisional audit identified shortfalls around safe storage of chemicals, hot water temperature monitoring, provision of communal areas for dining and recreation, an approved fire evacuation scheme.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Communication with residents and families is appropriately managed and recorded. Complaints are managed and residents and families are aware of the complaints process.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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WesleyCare is managed by an experienced registered nurse who has been in the role for over 30 years and reports to the chief executive officer of the Methodist Mission board. Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The strategic plan has goals documented. Policies and procedures are in place to provide appropriate support and care to residents with rest home and hospital level needs. A documented quality and risk management programme is being implemented.

Staff receive ongoing training and there is a training plan being implemented for 2016. Rosters and interviews indicate that there are sufficient staff who are appropriately skilled.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Assessments, care plans and evaluations reviewed were completed by a registered nurse within the required timeframes. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents and relatives interviewed were complimentary about the food service.

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>Some standards applicable to this service partially attained and of low risk.</p>
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The building holds a current warrant of fitness and a certificate for public use. WesleyCare has documented processes for waste management. Annual testing and tagging of electrical equipment and calibration and service of medical equipment has been conducted when required. All equipment has been purchased and is in use. There are sufficient bathroom facilities including full ensembles for all rooms. The service has policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. Rooms are appropriately heated and ventilated. Residents are provided with safe and hygienic cleaning and laundry services, which are appropriate to the setting.

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.
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WesleyCare has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. There were four hospital residents with restraint and one hospital resident with an enabler.

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.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

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	18	0	8	2	0	0
Criteria	0	51	0	8	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: 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 resuscitation directives were recorded as evidenced in the six resident files reviewed (two rest home and four hospital). Not all files evidenced that advanced directives were appropriately signed by the resident. Advised by staff that family involvement occurs with the consent of the resident. The previous audit finding remains an area for improvement.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and procedures have been implemented, and residents and their family/whānau are provided with information on admission.</p> <p>The complaints policy is posted in a visible area with complaints forms and advocacy information nearby. The residents and families interviewed were aware of the complaints process and to whom they should direct complaints.</p> <p>The service has received six complaints in 2016. All complaints reviewed have been responded to in a timely manner with investigations and responses communicated to the complainants. Two of the six complaints were received via the Health and Disability Commissioner's office. One of these complaints has been responded to and signed off as resolved. One is recent and is still undergoing review by the service.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Four hospital relatives interviewed stated they are informed of changes in health status and incidents/accidents. This was confirmed on incident forms reviewed. Seven residents interviewed (three rest home and four hospital) also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur. 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). If residents or family/whānau have difficulty with written or spoken English, then interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Surveillance: WesleyCare is governed by the Methodist Mission Board. A chief executive officer (CEO) is responsible for all aspects of the mission. The residential aged care service provided at WesleyCare is one of four aspects of the Boards work. The manager of WesleyCare reports to the CEO on a monthly basis. The organisation has a current strategic plan being implemented.</p> <p>WesleyCare provides care for up to 88 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 79 residents in total – 21 residents at rest home level, and 58 residents at hospital level including two younger persons with disability (YPD) contracts, one long-term chronic health condition contract (medical) and one ACC contract (medical). There were no respite residents.</p> <p>The new hospital building (Harewood Hospital) is a two-storey facility with 28 bedrooms on the ground floor and 30 bedrooms on the first floor. All rooms are dual-purpose. On the day of audit, there were 25 hospital and two rest home residents on the ground floor, and 23 hospital and three rest home residents on the first floor. The older adjacent wing (Marblewood) has a 12 hospital-level studio unit wing with 10 hospital level residents, and two units of 8 beds each which are all rest home level and were fully occupied.</p> <p>The service has been managed by an experienced manager who has been in the role for over 30 years. The manager reports monthly to the board on a variety of management issues. The current strategic plan, and quality and risk management plans have been implemented. The manager (registered nurse) receives support from a deputy manager (registered nurse), two clinical nurse managers, registered nurses and care staff.</p> <p>The manager has completed eight hours of professional development related to</p>

		<p>managing a rest home and hospital facility.</p> <p>Partial Provisional: There has been no change in the organisation structure of WesleyCare. The reporting and meeting systems have continued as per strategic plans. The 58 bed, two-storey hospital building has been in use since July 2015. A partial provisional audit was not conducted prior to opening of the new facility. The old three-storey building was demolished and the residents were transferred to the new building. The new build is stage one of a two stage redevelopment. Stage two is currently underway.</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>Partial Provisional: In the absence of the manager, the deputy manager is responsible for the running of the facility. There are also two clinical nurse managers in Harewood hospital.</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>The quality manual and the business, quality, risk and management planning procedure describe the WesleyCare home and hospital's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the quality assurance meeting, and the various facility meetings. Monthly and annual reviews have been completed for all areas of service. Meeting minutes have been maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with registered nurses and healthcare 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 2016 is being completed. Areas of non-compliance identified at audits have not been actioned for improvement. The previous audit finding remains an area for improvement.</p> <p>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 residents' care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies are implemented for individual</p>

		<p>residents. Residents' are surveyed to gather feedback on the service provided. Outcomes have not been collated for corrective actions. The survey results have been communicated to residents, staff and families via meetings.</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>	PA Low	<p>The accident/incident process (exception reports) includes documentation of the incident and analysis and separation of resident and staff incidents and accidents.</p> <p>A sample of resident incident and accident reports for July and August 2016 were reviewed. All reports were complete and evidenced timely clinical review of the resident with further investigations and analysis conducted as required. Not all pressure injuries have been reported. Accidents and incidents are analysed monthly with results discussed at quality assurance and health and safety meetings.</p> <p>The manager is aware of situations that require statutory reporting. The unstageable pressure injury identified during the audit was reported to the MOH via a section 31 notification on the day of audit.</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>Surveillance: Eight staff files were sampled (two clinical nurse managers, two registered nurses (RN), one enrolled nurse (EN), two health care assistants and one diversional therapist). Documentation including orientations and appraisals were completed. Current annual practicing certificates are kept on file.</p> <p>There is a fully implemented and comprehensive training plan in place. There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to) medication management and syringe driver training and competencies. Senior health care assistants also complete medication training and competencies. Residents and families state that staff are knowledgeable and skilled.</p> <p>Partial Provisional: Existing staff were retained for the move to the new hospital building, as resident numbers did not change. Recruitment of new staff has occurred as required.</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>Surveillance: There is a documented rationale for staffing the service. Staffing rosters were sighted and staff are on duty to match needs of different shifts and needs of different individual residents. Registered nursing cover is provided 24 hours a day, seven days a week. Sufficient numbers of healthcare assistants support RNs. Interviews with the residents and relatives confirmed staffing</p>

		<p>overall was satisfactory.</p> <p>Partial Provisional: The rosters for staffing cover of the new building remained unchanged, as resident numbers did not change.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Surveillance: The facility has recently introduced and implemented an electronic medication management system. Medicine trolleys were not evidenced to be appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed is not consistently signed as given, as prescribed on medication charts reviewed on the electronic medication management system. Staff who administer medication have been assessed as competent. The facility uses a blister pack medication management system for the packaging of all tablets. The RNs reconcile the delivery and this is documented. Medication charts are written by medical practitioners and there was evidence of three monthly reviews by the GP. Medications are prescribed and charted in-line with guidelines including indications for use for as needed medications. Competency assessments for residents self-administering medications were not evidenced to be completed.</p> <p>Partial provisional: There are medication management policies and procedures in place, which relate to aged residential care. The service has recently introduced an electronic medication management system. Medications are blister packed by the pharmacy and are checked on arrival from the pharmacy by a registered nurse. All staff who administer medications have completed a medication competency. The service has a policy and procedure for residents who wish to self-medicate that advises three monthly assessments by GP of the resident's ongoing ability to safely self-medicate and a resident competency review form.</p> <p>The new hospital building does not have treatment rooms for the storage of medication trolleys on the first and ground floor areas. On the first floor, medications for the ground and first floor hospital residents were evidenced stored in a locked steel storage cabinet in a storeroom. This locked storage cabinet included inside, a locked safe for the storage of controlled medications. However, the first floor storage room and medication trolley were not evidenced to be locked. On the ground floor a medication trolley, which was in use, was evidenced to be stored in a bathroom in the temporary clinical manager's office. The bathroom was not able to be locked from the outside, the room was not observed to be locked when left unattended. Medication fridge temperatures</p>

		are monitored weekly. In the new hospital building, medication is stored in a fridge in the designated temporary clinical manager's office on each floor. The medication treatment rooms are to be built as part of stage 2 (by end of 2016).
<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>Surveillance: The food service is provided by trained staff in a large well-appointed kitchen. The kitchen is located between the rest home and new building. There is a dining room in the rest home and studio apartment area (hospital) and tray service is provided to residents who are unable to attend the dining room. Food service manuals are in place to guide staff. A resident dietary profile is developed for each resident on admission and is provided to the kitchen staff. The kitchen is able to meet the needs of residents who require special diets and the cooks work closely with the registered nurses. Kitchen staff have completed food safety training. The cooks follow a rotating menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are routinely monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.</p> <p>Partial provisional: There is a large well-equipped kitchen which is located between the rest home and new building. Kitchen staff have completed food safety, infection control and chemical safety training. Dining areas in the new hospital building (stage 2) have not yet been built (link to 1.4.5.1). Trestle tables were observed set up along the ground and first floor corridors of the new building and residents were observed having their lunchtime meal and afternoon tea seated around these tables. There is a five weekly rotating menu, and residents interviewed advised that an alternative choice was available when requested. Food service manuals are in place. Any special dietary needs were observed written on large whiteboards in the kitchen and in a folder containing the individual resident's dietary profiles, which have been completed by a registered nurse. Food is transported from the kitchen to the rest home, studio (hospital) and new building in heated, insulated trolleys. There is also a cold storage transport insulated trolley for salads and cold desserts. Food temperatures are recorded prior to leaving the kitchen and prior to serving of meals. Temperatures of fridges and freezers are monitored and recorded.</p>
Standard 1.3.4: Assessment	PA Low	The previous certification audit identified that pain assessments were not

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>consistently completed to assess the effectiveness of pain management strategies prescribed for individual residents. On a review of care plans, pain assessments and electronic medication signing sheets for two residents who experience episodes of acute pain, the issue has now been resolved. However, behavioural assessments were not evidenced completed for all residents with challenging behaviours.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Progress notes document the care delivered on each shift following the prescribed care interventions documented in the residents care plans. If external nursing or allied health advice is required, the RNs will initiate a referral. Staff have access to sufficient medical supplies including dressings. Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Monitoring forms are in place for restraint use, fluid balance charts, turning charts and pain management and weight monitoring. However, not all care plans addressed changes in nutritional needs of residents with documented weight loss. Not all care plans were evidenced to address the falls prevention strategies that were being implemented to minimise the risk of falls, prevention or management of pressure injuries, or management of constipation.</p> <p>Wound documentation is available and includes assessments, management plans, progress and evaluations. There was one rest home resident with chronic leg ulcers and input from external wound care nurse specialist and GP was documented, there were six hospital residents with wounds including one resident with an unstageable pressure injury, two stage 2 pressure injuries; one stage one pressure injury; two residents with skin tears; and one resident with wounds following surgical interventions. Wound assessments and treatment plans reviewed did not document the classification (stage) of pressure injury. The RNs have attended wound care training.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are two activities staff who facilitate the activities programme for all residents, both are diversional therapists. Each resident has an individual activities assessment on admission and from this information, an individual activities plan has been developed by the activities staff for the resident files sampled. The activities programme reflects the residents' cognitive and physical abilities. Activities are provided for each morning and afternoon by activity staff from Monday to Friday. Healthcare assistants deliver the activity programme at</p>

		<p>weekends. The facility has a mobility van which is used for resident outings. Volunteers provide one-on-one visiting for residents and these visits are coordinated by the activity staff with the volunteers being matched up with residents with similar interests.</p> <p>Each resident is free to choose whether they wish to participate the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. Residents and families interviewed commented positively on the activity programme.</p> <p>There is a large chapel in the facility, which is currently being used to facilitate group activities as the lounges and communal areas for the new building, Harewood, have not yet been built (link 1.4.5.1). Residents on the ground and first floors of the new building were observed to be participating in activities on trestle tables set up in the corridors. Residents in the studio apartments join in the activities provided in the communal areas in the rest home or in the chapel.</p> <p>'Life friends' is the volunteer programme within the service which provides a visiting service for residents who prefer one-on-one activities. There are links with the local children's playgroup and residents grow vegetables to share with the playgroup. The residents also bake dog biscuits for the local animal shelter and SPCA.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plans reviewed were evaluated at least six monthly. Reviews document progress toward goals. There is at least a three monthly review by the GP. Care plan reviews are signed by an RN. Short-term care plans were evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files sampled. Not all changes in condition were documented in care plans (link to 1.3.6.1).</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>	<p>PA Low</p>	<p>Partial Provisional: Waste management procedures are addressed in the health and safety policy manuals. Staff have been provided with safe chemical handling training. A housekeeping manager is employed to oversee the food service, cleaning and laundry processes. There is provision for secure chemical storage in lockable cleaners' utility rooms. Chemicals were observed in two sluice rooms in the hospital building (Harewood) and were not securely stored. Appropriate sharps bins are available. Personal protective equipment is</p>

		provided for staff.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>Surveillance: The service displays a building warrant of fitness which expires on 1 January 2017.</p> <p>Partial Provisional: A certificate of public use has been issued on 28 June 2016 and is current. The building work for stage 1 of redevelopment of WesleyCare is complete. Stage 2 is underway and is cordoned-off from stage 1 by way of walls and barriers. The stage 1 building consists of a two-storey facility with resident rooms, a new kitchen, a new laundry and new entrance and car parking area. Stage 2 will extend from both floors and continue to join again at both ends. The current stage 1 build does not include dining and lounge areas. There is a sluice room on both floors. Stage 2 build includes a large dining room and large lounge area on both floors. Hot water temperature monitoring records evidence consistent temperatures over 45 degrees Celsius.</p> <p>All required equipment has been provided including oxygen concentrator, blood pressure machines, standing and sling hoists, and scales. Medical equipment including scales has been checked and calibrated. Hoists have been checked and serviced. The ground floor of Harewood hospital building includes 28 dual-purpose rooms each with full ensuites. The first floor has 30 dual-purpose bedrooms, each with full ensuites. Flooring surfaces and window coverings have been installed.</p> <p>Residents have their own possessions and adorn their rooms as they wish. Fixtures and fittings have been installed. All beds are electric beds and all beds have posture temp mattresses. Each room in the Harewood hospital has been fitted with a bed, a recliner chair, a set of drawers, a chair, and a wardrobe. The service has health and safety policies and hazard registers in place. There are paths and gardens around the facility. Other gardens can also be accessed from the old wing (Marblewood). A large internal garden is being constructed as part of stage 2 development.</p> <p>The policy on transportation and vehicle usage describes transportation requirements. Smoke detectors, fire alarms, a lift and sprinkler systems have been installed throughout the building. There is a stairwell at the north end of the building.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate</p>	FA	<p>Partial provisional: All 58 new rooms in the Harewood hospital have full ensuite bathrooms. Communal and public toilets have privacy locks installed.</p>

<p>toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>The service has shower seats and shower chairs on wheels. There are also over toilet seats available. Residents requiring assistance are able to be safely managed within all bathrooms.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Partial provisional: The Harewood hospital facility comprises two floors with 28 bedrooms on the ground floor and 30 bedrooms on the first floor. All rooms are of sufficient size to accommodate either rest home or hospital residents. All rooms are spacious enough to allow residents to safely move about with mobility aids and for the use of a hoist. There is adequate space to allow residents to personalise their rooms. All rooms are fully furnished.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	PA Low	<p>Partial provisional: Residents who reside in the new Harewood hospital building do not have close access to a dining room or lounge area. The Marblewood unit has a large chapel area which is used for church services, activities and functions. A dining area in this unit is available to residents if they choose to make the trip across to this area. At present, residents dine in either their rooms, or in the hallways of the Harewood building.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Partial provisional: The service has policies and procedures in place for the management of laundry and cleaning practices. The household manager oversees the cleaning and laundry systems and processes. A new laundry area has been built. Designated staff provide the cleaning and laundry service. Cleaning chemicals are stored securely with exception of sluice rooms in the hospital area (link 1.4.1.1). The new laundry includes two large washing machines and two large driers. There is a clean/dirty flow throughout the laundry area. Staff have been provided with chemical safety training. Cleaning and laundry audits are included in the annual audit schedule.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>Partial provisional: Emergency management plans are documented for WesleyCare to ensure health, civil defence and other emergencies are covered. Fire and evacuation training has been provided. Appropriate training, information, and equipment for responding to emergencies are part of the orientation of new staff. There is an emergency management manual, and a fire and evacuation manual.</p> <p>External providers conduct system checks on alarms, sprinklers, fire reels and extinguishers. Annual fire and evacuation training is compulsory for all staff who work for WesleyCare. First aid training has been provided for all registered</p>

		<p>nurses and senior healthcare assistants.</p> <p>The service does not yet have an approved New Zealand Fire Service fire evacuation scheme for the new building. Emergency lighting is provided by way of battery backup. Civil defence supplies are available including sufficient stored water. The call bell system has been installed and is fully functional. Call bells are situated in communal areas, bedrooms and bathrooms. The system includes lights over doors and call bell light panels. There are two nurses' stations – one on each floor. Staff conduct regular checks on residents within the facility and ensure that the facility is secure at night. The building work for stage 1 of Harewood hospital has been completed. The building work for stage 2 is underway and is managed by a project manager. All building areas are cordoned and walled-off to prevent access from the area. All contractors and visitors must present to the reception area and sign in and out.</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>	FA	<p>Partial provisional: General living areas, hallways and bedrooms are heated by underfloor heating and heat pumps. The facility was warm on the day of audit. All rooms have windows for ventilation. Residents have access to light in their rooms and there is adequate light in communal areas. The service is smoke free.</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>	FA	<p>Partial provisional: WesleyCare has an infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the designated infection control coordinator, with support from the deputy manager. The infection control programme is linked into the incident reporting system. Discussions around infection prevention and control are included in the quality assurance meeting. The infection control programme has been reviewed annually. Audits are conducted including hand hygiene, infection control practices, laundry and cleaning. Education has been provided for staff.</p> <p>The infection-control programme is managed by a registered nurse, who has completed appropriate training. Handwashing facilities and alcohol hand gel are available throughout the Harewood facility. Linen trollies are kept in each wing of the Harewood facility. Commercial covers have been purchased and fixed to linen trollies.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p>	FA	<p>Surveillance: Infection surveillance is an integral part of the infection control programme and is described in WesleyCare Home and Hospital's infection</p>

<p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>control manual. A registered nurse is the infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the quality assurance meetings. If there is an emergent issue, it is acted-upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Surveillance: The service has documented systems in place to ensure the safe and appropriate use of restraint. One hospital resident had two restraints - a bed rail and lap belt. There are five hospital residents with enablers, which were bedrails. One of these residents also has a full harness on a wheelchair and was in use on day of audit (observed).</p> <p>Policies and procedures include the definition of restraint and enabler that are congruent with the definitions in NZS 8134.0. Enablers are voluntary. Enabler documentation is the same as for restraint. Two enablers and two restraint residents' files were reviewed. Documentation included assessment, consent, risk assessments, care planning, monitoring and review. Staff education on RMSP/enablers has been provided.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The previous audit identified that the risks around the use of restraint were not documented in care plans. A review of two resident files requiring the use of a restraint (one with a bed rail and one with lap belt) evidenced that the risks associated with the use of restraint were documented in the care plans. The service has addressed this previous audit finding</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	Three of six files reviewed evidenced that advanced care planning documentation had been completed and signed by the resident, in discussion with the general practitioner and registered nurses.	Three files reviewed evidenced that advanced care planning directives had been signed by the resident's family or EPOA.	<p>Ensure that advanced directives are signed by the resident (deemed competent).</p> <p>60 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 2015 has been completed and a schedule is in place for 2016. Areas of non-compliance identified at audits or from other quality data have been identified for improvement however, corrective action plans have not been developed. The survey conducted	Corrective actions have not been developed following internal audits, resident survey, or hot water temperature monitoring, where shortfalls have been identified.	<p>Ensure that corrective actions are developed where shortfalls in service have been identified.</p> <p>60 days</p>

		in 2014 has not been collated or opportunities for improvement identified.		
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	Incident reports have been completed for resident falls, skin tears, bruising, medication errors and staff incident and accidents. Pressure injuries identified during the audit have not been reported.	Pressure injuries have not been reported via the incident and accident reporting process.	<p>Ensure that all adverse events including pressure injuries are reported via the incident and accident reporting processes.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	Surveillance and partial provisional: The rest home and studio apartments have designated areas for the secure storage of medication and medication trolleys. However, secure and safe storage of medication trolleys was not evidenced in the new building. Ten of twelve electronic medication signing-sheets reviewed evidenced medications had been given as prescribed. The medication treatment rooms are to be built as part of stage 2 (by end of 2016).	<p>i) Medication trolley on first floor of new building was observed stored in an unlocked room and the trolley was not locked; and the medication trolley on ground floor of new building was evidenced stored in an ensuite bathroom of clinical manager's temporary office, which was unlocked. Since the draft report the service has advised; The trolley is always locked and a digital lock has been added to door since audit.</p> <p>ii) Oxygen administration for two residents (one hospital, one rest home), recorded on electronic signing-sheets did not evidence length of time of administration or recording of observations as per GP instructions on medication chart</p>	<p>i) Ensure that there is safe and secure storage for medication trolleys.</p> <p>ii) Ensure electronic medications evidence that medications have been administered and observations recorded as per GP instructions.</p> <p>30 days</p>

<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>Surveillance: The service has a policy and procedure for residents who wish to self-medicate that advises three monthly assessments by GP of the resident's ongoing ability to safely self-medicate and a resident competency review form are completed. One resident who self-administers medications was not observed to have an assessment completed.</p>	<p>One of one hospital resident who self-administers medication (inhalers) did not have an assessment completed to evidence the resident's ongoing ability to safely self-administer medication. The resident's care plan did not identify that the resident self-administers medication.</p>	<p>Ensure assessment for competency to self-administer medication is completed for all residents who self-administer medications, and self-administration of medication is documented in care plan.</p> <p>60 days</p>
<p>Criterion 1.3.4.2</p> <p>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.</p>	<p>PA Low</p>	<p>Clinical assessment tools were evidenced completed to identify resident risk and these included InterRAI, nutritional, falls risk and pressure injury risk assessments, which were observed completed in resident files reviewed. Five of six resident files evidenced completed risk assessments relating to falls, pain, pressure area risk and continence.</p>	<p>A behavioural assessment was not evidenced completed for one hospital resident who displayed episodes of verbal and physical aggression. Incident forms were evidenced completed for recent episodes of challenging behaviour; however, these episodes were not documented in progress notes or on a behavioural chart.</p>	<p>Ensure that a behavioural assessment, and behavioural chart is completed for residents with challenging behaviours.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Wound assessment and treatment plans were evidenced completed for all wounds. However, four of four pressure injuries currently being treated, the wound assessment and treatment plans did not document the stage of pressure injury. Pressure relieving strategies that were observed implemented were not</p>	<p>(i) Four wound assessments and wound management plans for four pressure injuries currently being treated, did not document the stage of pressure injury.</p> <p>(ii) The management of weight loss for two residents, one with weight loss of 4kg recorded over one month and another over three months, who had</p>	<p>(i) Ensure the classification of pressure injury is documented on wound assessment and treatment plans.</p> <p>(ii) Ensure care plans reflect the weight management strategies as recommended by GP.</p>

		<p>documented in the care plans of four of four residents with pressure injuries. Monitoring of residents' weight was observed to be recorded monthly or more frequently as prescribed by GP. However, the management of recent weight loss for two of two hospital residents with 4kg weight loss was not documented in care plans. Falls prevention strategies were documented in all six care plans reviewed. However, one care plan for a hospital resident assessed as a high falls risk did not document the current falls prevention strategies that were observed in place, which included a sensor mat that was placed on chair when seated and on top of mattress when in bed. The management of the elimination needs of residents was documented in five of six care plans reviewed; one care plan did not document recently prescribed treatment for the management of constipation in the residents care plan.</p>	<p>been reviewed by a GP, was not documented in the care plans reviewed.</p> <p>(iii) The use of pressure-relieving devices evidenced in use was not fully documented in care plans reviewed for four residents with pressure injuries.</p> <p>(iv) Falls preventions strategies/equipment observed in place for a resident assessed as a high falls risk were not documented in the care plan.</p> <p>(v) Recent changes to a resident's bowel habits and prescribed treatment by GP were not reflected in the residents care plan.</p>	<p>(iii) Ensure the pressure-relieving equipment in use is documented in care plans.</p> <p>(iv) Ensure falls prevention strategies and equipment in use to minimise the risk of falls is documented in care plans.</p> <p>(v) Ensure recommendations by GP regarding changes to present treatment plan are documented in care plans.</p> <p>60 days</p>
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies</p>	<p>PA Low</p>	<p>Partial Provisional: Chemicals were stored securely in cleaners' cupboards. Two sluice rooms (one on the ground floor and one on the first floor) were not locked. Cleaning chemicals were noted on shelves in both sluice rooms.</p>	<p>Partial Provisional: Cleaning chemicals are not stored securely on both floors of the Harewood hospital building. Since the draft report the service has advised that electronic locks have been added to sluice rooms to enable chemicals to be secure.</p>	<p>Partial provisional: Ensure that all chemicals are stored safely and securely.</p> <p>30 days</p>

with current legislation and territorial authority requirements.				
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Moderate	<p>Partial provisional: Hot water temperatures for the whole service were reviewed. Temperatures are recorded monthly across a random selection of resident rooms. Temperatures were noted to be above the required temperatures.</p>	<p>Partial provisional: Hot water temperatures in the Harewood hospital have been consistently noted to be in excess of 45 degrees Celsius. Temperatures ranged from 43 to 51 degrees Celsius. No corrective actions have been actioned.</p>	<p>Partial provisional: Ensure that hot water provided in resident areas does not exceed 45 degrees Celsius as per building code regulations.</p> <p>30 days</p>
<p>Criterion 1.4.5.1</p> <p>Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.</p>	PA Low	<p>Partial provisional: Tables and chairs are set up in the hallway on both floors for mealtimes. There are some small alcoves, where seating is able to be set up for dining. The hallways are wide and allow residents to move about as well as sit and dine. Stage 2 of the redevelopment includes large dining and large lounge areas on each floor. Residents and family interviewed advised that they are aware that the dining arrangements are temporary and that staff manage the meal service as well as possible.</p>	<p>Partial provisional: Appropriate dining and lounge areas have not yet been provided for residents in the Harewood hospital area. This is currently in stage 2 of the build.</p>	<p>Partial provisional: Ensure that appropriate and adequate access to lounge and dining facilities is provided for residents.</p> <p>180 days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	<p>Partial provisional: A comprehensive fire evacuation plan has been developed by an external provider. Temporary emergency procedures for Harewood building have been in</p>	<p>Partial provisional: The fire evacuation plan has not been approved by the NZ Fire Service.</p>	<p>Partial provisional: Provide evidence that the NZ Fire Service has approved the fire evacuation scheme.</p>

		place since July 2015. The plan has not yet been approved by the New Zealand Fire Service. Fire evacuation drills are conducted six monthly and fire and emergency training has been provided to staff.		90 days
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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.

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End of the report.