

G J & J M Bellaney Limited - Wimbledon Villa

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: G J & J M Bellaney Limited

Premises audited: Wimbledon Villa

Services audited: Dementia care

Dates of audit: Start date: 6 October 2016 End date: 7 October 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 22

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

Wimbledon Villa is a privately owned facility which provides secure dementia care for up to 38 residents. On the day of audit there were 22 residents. A clinical nurse manager and facility manager are responsible for the daily operation of the facility. They are supported by a quality coordinator, registered nurses and care staff. Family members interviewed spoke positively about the care and services provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

This audit has identified that improvements are required around incident reporting, the completion of short-term care plans and InterRAI assessments, restraint monitoring and access to rooms.

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.
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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The manager (business) is supported by a clinical nurse manager and quality coordinator. Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded. Data is collected, analysed, discussed and changes made as a result of trend analysis. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Residents and families report that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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.		Some standards applicable to this service partially attained and of low risk.
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. InterRAI assessments are in place for all residents. The care plans are resident and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. Relatives interviewed confirmed that they were happy with the care provided and the level of communication.

Medication management policies and procedures are in line with legislation and current regulations.

Planned activities are appropriate to the resident's assessed needs and abilities and relatives advised satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. The kitchen is well equipped for the size of the service. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. There are two 18-bed units within the facility. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definition in the restraint minimisation standard. The service had one resident requiring the use of a restraint. Staff receive education and training in restraint minimisation, dementia care and managing challenging behaviours.

Infection prevention and control

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

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. 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. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Benchmarking of results occurs.

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	47	0	3	0	0	0
Criteria	0	98	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Wimbledon Villa policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme.</p> <p>Interviews with care staff (three healthcare assistants, two registered nurses (RNs) and the diversional therapist), confirmed their understanding of the Code. Three relatives interviewed confirmed that staff respect privacy, and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Written consents were completed. Five resident files sampled demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare assistants and the registered nurse interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents.</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>Advocacy information is available to residents in the service entrance. Interviews with residents and family confirmed they were aware of their right to access advocacy.</p> <p>Residents confirm that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the resident's family. Staff training in Code of Rights and advocacy has been provided.</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>Relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care. The service assists visiting with providing transport for some family members.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>A tour of the premises confirmed staff support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident</p>

<p>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>rooms. Staff could describe definitions around abuse and neglect that aligned with policy.</p> <p>An annual relative satisfaction survey was completed in September 2016 and the results showed that overall experience was reported as being good or very good by 90% of respondents. Relatives interviewed confirmed that staff treat residents with respect.</p> <p>Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with healthcare assistants described how choice is incorporated into resident cares (link to 1.4.5.1 as one wing is closed during the day, restricting resident's access to their rooms).</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>here is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Staff receive cultural training provided by Te Runanga O Raukawa, this is supported by a cultural safety work book for staff to complete.</p> <p>Cultural needs and support is identified in care plans. Individual care plans include the cultural needs of residents. There were no residents who identified as Māori.</p> <p>The policies for Māori identify the importance of family/whānau. Staff interviewed were aware of the importance of family involvement. Discussion with family members, confirm that they are regularly involved.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and family are invited to attend. Relatives interviewed confirm that staff take into account their culture and values.</p> <p>Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Staff sign a code of conduct, house rules, and confidentially agreements on employment. Comprehensive policies and procedures provide guidelines and mentoring for specific situations. Interviews with staff confirm an awareness of professional boundaries. Interview with healthcare assistants could discuss professional boundaries in respect of gifts.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are robust policies and procedures in place that meet the health and disability safety sector standards. Staff state they are made aware of new/reviewed policies and sign to say they have read them. Staff report that the manager and clinical nurse manager are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The RNs have access to external training. Discussions with residents and family were positive about the care they receive.</p> <p>The service has upgraded the external environment with attention given to making the gardens brighter and more colourful. This included a tactile and sensory garden.</p> <p>The service has liaised with Hammond Care Australia to improve the service. This has included ensuring walking loops for residents.</p> <p>As a result of research, and to assist residents to feel less confused, the service is in the process of introducing full sized images on their bedroom doors to help residents familiarise themselves with their surroundings.</p> <p>Medication management is now implemented using an electronic system.</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>There is a policy to guide staff on the process around open disclosure. The manager and clinical nurse manager confirm family are kept informed. Relatives stated they are notified promptly of any incidents/accidents. Resident meetings encourage open discussion around the services provided (meeting minutes sighted).</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. Dementia specific information is provided to family members.</p> <p>Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. All 13 incident forms reviewed from August 2016 identify family were notified following a resident incident. Interview with staff confirms that family are appropriately notified following a resident change in health status.</p> <p>Relatives interviewed stated that they are informed when their family member's health status changes or of any other issues arising.</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>Wimbledon Villa is privately owned. The owner is readily available to the management team. The facility manager and the clinical nurse manager provide monthly reports to the owner (sighted). The service provides secure dementia care for up to 38 residents across two units. On the day of audit, there were 22 residents (10 of 18 in Rose wing and 12 of 18 in Courtyard villa wing). All residents were under the ARRC agreement. There were no respite residents.</p> <p>The service has a business plan 2016 to 2017. The business plan identifies the purpose, values and scope of the business. The service has quality goals which are reviewed regularly. Annual reviews of service performance are documented and include health and safety, internal audits, meetings and quality objectives.</p> <p>The facility manager, who has a management and business background and has been a manager at the facility since September 2010, supports the clinical nurse manager. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</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>	<p>FA</p>	<p>The clinical nurse manager covers during the temporary absence of the facility manager.</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>	<p>FA</p>	<p>Wimbledon Villa has a documented quality assurance and risk management programme in place. The service employs an internal auditor and a quality coordinator who coordinates and records quality data, and develops corrective actions plans and collates results. Quality activity information is communicated to the owners, management and staff. Corrective action plans for internal audits and other quality outcomes including incident and accidents, infection control, and complaints are documented on a database and reviewed through monthly meetings until completion.</p> <p>A documented and implemented internal audit schedule includes an annual review of audit results for the year. Each month, the quality coordinator collates incidents and accidents data, and infection control. Incidents are collated monthly onto a reporting sheet to monitor issues and trends and these are displayed on the staffroom noticeboard (link to 1.2.4.3 as not all incidents have a documented incident form). Monthly data analysis includes the comparison against set KPIs for the service, which</p>

		<p>are also benchmarked against similar services.</p> <p>Annual analysis is also documented and presented to the staff, quality and management meetings. A report is presented to monthly staff and quality meetings, monthly team management meetings and a monthly report to the owner, as evidenced in meeting minutes.</p> <p>Annual relative surveys have been completed. The survey (September 2016) documents an improvement for 'very satisfied' from 57% compared to 54% for the previous year. Satisfaction results were reported in staff meetings and communicated to relatives via a newsletter.</p> <p>The facility implements organisational policies and procedures to support service delivery. These have been sourced from an external contractor. All policies are scheduled for review every two years. Policies are available to staff and have been updated to reflect the implemented InterRAI procedures.</p> <p>Health and safety policies and procedures, and a health and safety plan are in place for the organisation. The hazard register is regularly reviewed. All identified hazards include a risk rating, controls that are in place and monitoring procedures.</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>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise. Accidents/incidents were also recorded in the resident progress notes and changed to care plan documented as needed. There is documented evidence the family had been notified promptly of accidents/incidents.</p> <p>A review of 13 incident/accident forms identified that these forms were fully completed. The completed form is forwarded to the clinical nurse manager for final sign off, and the quality coordinator for data entry and trending.</p> <p>Not all incidents have a corresponding incident form documented.</p> <p>Four section 31 notifications are recorded; these include two absconding residents, one interruption in services due to recent flooding in the area and one instance where the police had been called. All section 31 notifications included appropriate follow-up and resolution by the service.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (the clinical nurse manager, one other registered nurse, the activities coordinator and two healthcare assistants) included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions; completed orientation programmes and annual performance appraisals. A register of registered nursing staff and</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice.</p> <p>The training programme includes both internal and external training for healthcare assistants (HCAs) is well established. There is a tracking system that ensures all HCAs achieve at least 8 hours of in-service education per year. All HCA's have either completed or are working towards unit standards for dementia care. Those who have completed dementia care standards are continuing study towards the NZ Certificate in Health and Wellbeing (Level 3) Health Assistance.</p> <p>The service's aim of 70% of HCAs holding a first aid certificate has been met. This ensures there is a first aider on every shift. This training has now been extended to include catering staff, maintenance and housekeeping staff.</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>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There is a clinical manager on duty Monday to Friday and at least one other RN on the morning shift Monday to Sunday. In addition, there is a minimum of two healthcare assistants on duty. A registered nurse is on call at all times.</p> <p>Staff working on the days of the audit were visible and were attending to call bells in a timely manner. Staff interviewed stated that overall, the staffing levels are satisfactory and that the managers provide good support. Family members interviewed report there are sufficient staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information is kept confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Files are integrated.</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>	<p>FA</p>	<p>Entry processes are recorded and implemented. The service's philosophy is communicated to residents, family, relevant agencies and staff. The facility information pack is available for residents and their family and contains all relevant information for dementia level care.</p> <p>The residents' admission agreements evidence family/EPOA and facility representative sign off. The admission agreement defines the scope of the service and includes all contractual requirements. The needs assessments are completed for dementia level care.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential aged care envelope when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.</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>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Each wing has a medication folder, medication trolley and a locked medication storage area. Medication administration practice complies with the medication management policy for the medication rounds sighted. The service uses an electronic medication management system. There was evidence of three monthly reviews by the GP. Registered nurses and healthcare assistants administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a blister packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. There were no residents self-administering medication on the day of audit. There are standing orders in place which comply with the Ministry of Health Guidelines (August 2016).</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 meals at Wimbledon Villa are prepared and cooked onsite. There is a four weekly seasonal menu, which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. Pureed, soft texture and diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. All food services staff have completed training in food safety and hygiene and chemical safety.</p> <p>Snacks, including fruit, biscuits, sandwiches, desserts and soups are available at all times.</p>
<p>Standard 1.3.2: Declining</p>	FA	<p>The service has accepting/declining entry to service policies. Reasons for declining entry would be if</p>

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six monthly or when there was a change to a resident's health condition. The InterRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Care plans sampled were developed on the basis of these assessments. One of three registered nurses are InterRAI trained.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>Resident files include all required documentation. The long-term care plan sampled recorded the resident's problem/need, objectives, interventions and evaluation for identified issues. Long-term care plans reviewed were evidenced to reflect the resident's needs. The service uses a short-term care plan for any acute resident needs. However, these were not consistently evidenced to be completed for all acute changes in resident condition. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Registered nurse follow-up of concerns documented in progress notes by healthcare assistants was not consistently documented.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses (RNs) and healthcare assistants follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse or wound care specialist nurse). If external medical advice is required, this is actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. There is one resident with a chronic leg ulcer being treated. The wound was evidenced to have been reviewed in appropriate timeframes. A wound assessment and treatment plan was evidenced to be completed and updated with any changes to treatment plan required following RN assessment at each dressing change. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses and healthcare assistants demonstrated an understanding of the</p>

		<p>individualised needs of residents. Care plan interventions demonstrate interventions to meet residents' needs. There was evidence of pressure injury prevention interventions such as encouraging and assisting residents to keep mobile and active, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</p> <p>Behaviour monitoring charts were evidenced to be completed in five resident files reviewed.</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>The activities coordinator is a qualified caregiver and diversional therapist, and is employed for 32 hours per week Monday to Friday. An activity assistant assists with activities as required (outings) and hours are increased with resident occupancy.</p> <p>The activities coordinator provides individual and group activities. The monthly programme is varied and appropriate for people with dementia and includes outings.</p> <p>The residents attend community events such as concerts, seniors club, and Lion's club functions with positive feedback from the community. Two staff accompany residents on outings in the van. The activities coordinator has a current first aid certificate. The improved access to community resources has resulted in a greater choice and the opportunity to attend more person-centred activities maintaining resident's past interests and involvement with their local community.</p> <p>Activities were observed to be occurring in small groups and on an individual basis. Ten residents were transferred from Rose wing into the Wimbledon wing after breakfast each morning to attend activities. There are resources available for care staff to use for one-on-one time with the resident and at any time of day and weekends.</p> <p>Relatives stated they were satisfied with the activities provided and can feedback on the programme. The service has responded to a need identified by relatives who require assistance to get transport to visit loved ones at the facility and now provides a door to door return shuttle service twice a week from Palmerston North to the facility. This was implemented in March 2015. The service has also extended its Wednesday Outing Club to include day care residents living with dementia from the wider Manawatu area.</p> <p>There has been a project implemented (now completed) to make the gardens brighter and more colourful. Relatives interviewed stated residents are enjoying the stimulation derived from the extra colour and the now tactile, sensory garden.</p> <p>A resident profile is completed on admission in consultation with the resident/family (as appropriate). Activity plans sighted in all five files were reviewed six monthly at the same time as the care plans. A recent review of all resident 24 hour activity plans detailing de-escalation and distraction techniques had occurred to reflect a more person centred approach.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six monthly or earlier if there is a change in health status. There was at least a three monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan (link 1.3.5.2).</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 service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes.</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>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were all stored safely throughout the facility. Safety datasheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The facility has a current building warrant of fitness that expires 8 July 2017. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes.</p> <p>There are two wings (units) which have 18 rooms each. Two bedrooms in one unit can be used as double rooms, however these were not occupied at the time of audit.</p> <p>The physical environment allows easy access, movement for the residents and promotes independence for residents with mobility aids. There are communal dining and lounge areas and</p>

		<p>smaller seating areas, alcoves and conservatories for more private areas and to allow for a low stimulus environment when needed.</p> <p>There is a part-time maintenance person who carries out maintenance requests and records corrective action in the maintenance book. There are monthly internal building and external building maintenance schedules in place. Water temperature monitoring of different rooms is carried out each month (sighted) and complies with regulations. The grounds are tidy, well maintained and able to be accessed safely. There are outdoor ramps with handrails, outdoor seating, shaded areas and raised garden beds.</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>	FA	<p>There are large communal toilets in both wings including shower rooms. There are some rooms in each wing which have ensuite facilities. The communal facilities are close enough and large enough to meet the needs of the residents. Fixtures, fittings and floor and wall surfaces are made of accepted materials for meeting hygiene and infection control practices. Communal toilets and showers are well signed and identifiable. There are engaged/vacant signs on the doors and privacy curtains. There are appropriately placed handrails in the bathrooms and toilets in the ensembles and communal areas.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Resident rooms were observed to be personalised.</p> <p>To help residents familiarise themselves with their surroundings the service has introduced using full size images on doors of items that have a personal meaning and are identifiable to each resident.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each wing has its own kitchenette and open plan dining and lounge areas. Furniture is arranged to allow residents to freely mobilise between the different areas of each home and to the outside. In both wings, the lounges are accessible and accommodate the equipment required for the residents. The service has no dead-end corridors and residents are able to join in different activities. At present the residents from Rose wing are brought into Wimbledon wing for activities after breakfast each morning from Monday - Friday and remain there until tea time (approximately 4.30pm), having lunch meals in the dining area in Wimbledon wing (link 2.2.3.2). There are cameras in areas away from the main lounges connected to surveillance monitors for resident safety. Residents have easy access to secure outdoor areas with raised flower, sensory and vegetable gardens, water features and art work of interest.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The service has in place policies and procedures for effective management of cleaning and linen practices. The laundry service is completed by an external contractor. A small amount of personal laundry is carried out by health care assistants. The cleaning trolleys are well equipped and all chemical bottles are labelled. Protective wear including plastic aprons, gloves and goggles are available in the two sluice rooms and laundry room. Staff observed on the day of audit were wearing correct protective clothing when carrying out their duties. Staff have received education in infection control and safe use of 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>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. The facility has emergency lighting, two generators, two water tanks, and a gas BBQ for alternative heating and cooking which can be used in the event of an emergency. Emergency food supplies sufficient for three days are kept in the kitchen. The staff interviewed could describe the emergency management plan and how to implement this. Fire training and security situations are part of orientation of new staff. A minimum of one person trained in first aid is rostered on each shift. There are call bells in the residents' rooms and lounge/dining room areas. There are sensor mats in use.</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>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</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</p>	FA	<p>The infection control programme and 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 clinical nurse manager. Minutes are available for staff. Infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p>

be appropriate to the size and scope of the service.		
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight and training and education of staff. The policies have been reviewed and updated annually.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information monthly. Surveillance data are used to determine infection control activities and education needs in the facility. Definitions of infections in place are appropriate to the complexity of service provided. Infection control data, identified trends and analysis are reported at the team (all staff) meetings. Monthly comparison and trends for infection rates are analysed on an</p>

that have been specified in the infection control programme.		individual basis. There have been no outbreaks. Systems in place are appropriate to the size and complexity of the facility. The service participates in external benchmarking.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There were policies and procedures in place should enablers be required. On the day of audit there was one resident requiring the use of restraint and no enablers. The resident had been assessed incorrectly for use of an enabler. It was determined at audit that the device was a restraint as the resident was unable to voluntarily request the use or removal of the enabler (a recliner chair with foot plate raised) (link to 2.2.3.4). The clinical nurse manager is the restraint coordinator. Restraint minimisation education and management of challenging behaviours is included in the training programme.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The clinical nurse manager is the restraint coordinator. Assessment and approval process for restraint use includes the restraint coordinator, registered nurses, resident/or representative and medical practitioner.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes an assessment for residents who require restraint or enabler interventions. These were undertaken by the restraint coordinator in partnership with the family/whānau in the one file sampled. The restraint coordinator, next of kin and a medical practitioner were involved in the assessment and consent process. In the one file reviewed, assessments and consents were fully completed, but had been assessed as an enabler and not a restraint (link to 2.2.3.4).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Low	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints and enablers. The file reviewed had a completed assessment form and a short-term care plan that reflected risk for the use of an enabler (restraint). However, the resident is not

		cognitively able to request the voluntary use or removal of an enabler. Monitoring forms did not evidence the frequency of monitoring was occurring within the prescribed timeframe.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	In the past the service has not had any residents requiring the use of a restraint. The resident now requiring the use of a restraint has recently, due to a decline in health status, required the use of a restraint to ensure safety. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at clinical management/quality meetings. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Evidence: In the past the service has not had any residents requiring the use of a restraint. The resident now requiring the use of a restraint has recently, due to a decline in health status, required the use of a restraint to ensure safety. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at clinical management/quality meetings. Evaluation timeframes are determined by policy and risk levels.

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 1.2.4.3</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	The service collects incident and accident data and reports aggregated figures to the quality meeting and the health and safety meeting. Staff interviewed confirm incident and accident data are discussed at the staff meeting and information and graphs are made available.	<p>Incident forms were not documented for all incidents. Examples included; one resident with bruises and bleeding (documented in progress notes) and one resident who was pinched by another resident (there was an incident form for the resident who was the</p>	<p>Ensure all incidents are recorded on an incident form.</p> <p>60 days</p>

			aggressor);	
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Long term care plans were evidenced completed in all resident files reviewed. Short-term care plans were not evidenced to be consistently completed and were not evidenced to reflect all allied health recommendations. Registered nurse follow-up of concerns documented in progress notes was not evidenced to be documented for a resident with bleeding reported from an area of bruising.</p>	<p>a) A short term care plan was not evidenced as completed for a resident with a current skin infection; b) registered nurse follow-up of a resident with bleeding from a bruised area (as documented in progress notes) was not evidenced to have occurred; and c) the short-term care plan for a resident with unintentional weight loss did not reflect all of the dietitian recommendations.</p>	<p>a) Ensure short term care plans are completed or the long term care plan updated when there is an acute change to resident needs or treatment plan; b) ensure registered nurse assessment and follow-up of concerns, as highlighted by healthcare assistants, are completed and documented; and c) ensure that short-term care plans reflect allied health recommendations.</p> <p>90 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p>	PA Low	<p>One resident requires the use of a recliner chair with the foot plate raised to ensure his safety. The resident is not cognitively able to request the voluntary use or removal of the enabler and is reliant on staff to put the footplate of the recliner chair down to move. Therefore, the use of equipment has been assessed incorrectly and is a restraint. The use of the recliner chair with foot plate extended had been discussed and</p>	<p>(i) The use of an enabler has been assessed incorrectly and was a restraint; and (ii) the monitoring of the restraint was not evidenced to be</p>	<p>(i) Ensure that the assessment process clearly identifies whether the equipment to be used is a restraint or an enabler; (ii)</p>

<p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>		<p>agreed to by the resident's EPOA and GP. Thus, the risk rating is assessed as low risk. Monitoring of the restraint was not occurring within the timeframes specified in the short-term care plan.</p> <p>Each wing has its own areas for dining, relaxation and activities. However, only one wing was evidenced to be utilised for the activity and dining needs of all residents during the duration of the audit. It is the current practise, as sighted documented in meeting minutes and on discussion with staff, that a number of residents from Rose wing are brought into Wimbledon wing for activities after breakfast each morning from Monday - Friday and remain there until tea time (approximately 4 - 4.30pm). The purpose of this, on discussion with the manager, is to improve attendance and ensure residents are meaningfully engaged in activities. These residents also have their lunch meals in the dining area in Wimbledon wing. The door to Rose Wing (accessed from Wimbledon dining area) is locked with a number keypad lock. The residents who reside in Rose Wing are unable to return to their own rooms without a staff member's assistance. Residents were observed attempting to open the locked door during the audit. This was addressed on the day of audit and staff reminded about ensuring residents have free access back to their rooms.</p>	<p>occurring at 30 minute intervals as specified in the short-term care plan;(iii) Residents are combined into one unit during the day, the consequence being that residents are not freely able to access their own unit/rooms as the door between is locked. This was addressed in the day of audit</p>	<p>ensure that the monitoring of the restraint is completed within the timeframes specified. (iii) Ensure residents can freely access their own rooms</p> <p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.