

Waihi Hospital (2001) Limited - Waihi Hospital & Rest Home

Introduction

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

The audit has been conducted by 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: Waihi Hospital (2001) Limited

Premises audited: Waihi Hospital & Rest Home

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

Dates of audit: Start date: 23 January 2017 End date: 24 January 2017

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: 28

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

Waihi Hospital and Rest Home is a privately owned and operated service that provides rest home, hospital (geriatric and medical) and maternity levels of care for up to 56 residents and clients. On the day of the audit there were 15 rest home residents and 13 hospital residents. There were no maternity clients. The residents and relative interviewed spoke positively about the care and support provided.

This certification audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management. Residents and family interviewed were complimentary of the service they receive.

This certification audit identified that improvements are required around training, maternity roster, long and short-term care planning, and medication management.

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 Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff training is provided on the Code.

The values and beliefs of residents are respected. 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.

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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Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager/registered nurse and second in charge/registered nurse are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Results are shared with staff. 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. An education and training plan is established and includes in-service education, online training and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week.

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 medium or high risk and/or unattained 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. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations.

All food is cooked onsite. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and the menu plans have been reviewed by a dietitian.

Maternity Services: Clients book with a Lead Maternity Carer (LMC) generally early in pregnancy during the antenatal period. They are assessed as to whether they are low risk and could use a primary birthing facility for labour/birth and postnatal care or could transfer from a secondary facility after birth for the postnatal episode of care. Postnatal care is provided within the facility by health care assistants under the direction of the LMC midwives or nurses from the hospital/rest home. An admission care plan is developed and evaluated by the LMC on a daily basis. These daily checks ensure that interventions are consistent and provide ongoing assessment of the needs of the client and her baby.

The maternity services are provided in a timely manner encompassing education, care provision, decision making topics and referrals as required. Clients (and partners) are provided with a choice of onsite home cooked meals. Medications are appropriately stored. Medication management including prescribing and administration are identified as not always followed as per legal and facility requirements.

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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Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

There is a designated laundry and cleaner's rooms. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. A register is maintained. During the audit two residents were using a restraint and four residents were using enablers.

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.

The infection control programme is implemented and meets the needs of the facility. Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and also 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.

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	45	0	3	2	0	0
Criteria	0	98	0	3	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	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 in-service programme (link 1.2.7.5). Interviews with eight staff (three healthcare assistants across the am and pm shifts, three registered nurses (RNs), one LMC, one activities coordinator) confirmed their understanding of the Code. Eight residents (three hospital level and five rest home level), one maternity client and five relatives (three hospital level and two rest home level) interviewed, confirmed that staff respect privacy, and support residents in making choices.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Six resident files sampled demonstrated that advanced directives are signed 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.

consent.		<p>Maternity service:</p> <p>Policies and procedures are in place at Waihi maternity for informed choice and consent that meet the requirements of the Code. These policies are adhered to and women are supported to make informed choices. Informed consent forms reviewed included consent for formula supplementation of a breastfed baby, vitamin K, placenta –take home, and anti D-blood products. Placentas are not stored onsite. The families are encouraged to take this home as soon as possible after the birth or alternatively the 'Waihi Maternity Annexe - Procedure for Return or Disposal of Placentas' provides clear instruction for disposal of the placenta by the facility. Families are welcome to bring in their own receptacle for the placenta.</p> <p>The consent forms were all evidence based, detailed and relevant in the five client files reviewed. Up-to-date information is available within the facility to support informed discussions and decision making for pregnancy and the postnatal period.</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>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on residents' family/whānau and chosen social networks.</p> <p>The role of advocacy services is covered in the online staff training programme (link to 1.2.7.5). Advocacy services are addressed in the complaints process. Complainants are provided with the opportunity to access this service, which is documented on the complaints register.</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>Residents and 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. Relatives and friends are encouraged to be involved with the service and care.</p> <p>Links are established with the DHB and associated specialty services (eg, mental health, wound care, district nursing), palliative care services, Alzheimer's Waikato, ear health, Arthritis Foundation, dental services, retired services association (RSA), local churches, friends of SPCA and St John volunteers.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms and brochures are available at the entrance to the facility. Information about complaints is provided on admission.</p> <p>Interviews with residents and relatives confirmed their understanding of the complaints process. Care staff</p>

understood, respected, and upheld.		<p>interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register that includes complaints received, dates and actions taken. The facility manager signs off each complaint when it is closed. Ten complaints were received in 2016 and one in 2017 (year to date). All complaints were documented as resolved. The complainant is requested to indicate that they are satisfied with the results. Complaints are being managed in a timely manner, meeting requirements determined by HDC.</p> <p>The complaints process is linked to the quality and risk management system. Corrective actions have been implemented where applicable. Staff are kept informed of complaints received.</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. Residents, relatives and maternity client interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The information pack is discussed with residents/relatives on admission. 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 Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>During the audit staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Care staff interviewed could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect. Missing was evidence that the residents' privacy is respected while using the toilets with no signage or privacy locks on toilet doors. This was addressed during the audit.</p> <p>Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with healthcare assistants described how choice is incorporated into residents' cares.</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</p>	FA	<p>The Māori health policy references local Māori healthcare providers and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. Links are established with Māori advocacy within the local community. This includes a designated kaumātua and a kuia. The building was blessed by Māori in 2016. Rooms of residents who pass are blessed by a kaumātua.</p> <p>Cultural needs are assessed on the Māori cultural assessment form and are addressed in the care plan.</p>

acknowledges their individual and cultural, values and beliefs.		<p>Missing was evidence of staff cultural training covering Māori values and beliefs (link to 1.2.7.5).</p> <p>During the audit there was one Māori resident living at the facility. They were not available for interview but their two whānau reported that the resident's cultural needs were being met by the facility and that they were very satisfied with the services their whānau was receiving.</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	Individual beliefs and values are discussed and incorporated into the care plan, evidenced in all six residents' files reviewed. Six-monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers (facility manager and second in charge (2IC) and care staff confirmed their awareness of professional boundaries.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Policies and procedures are aligned with current accepted best practice. The content is sufficiently detailed to allow effective implementation by staff. The service has established a culture of continuous quality improvement amongst the managers and staff. Two general practitioners (GPs) interviewed provided positive feedback around residents' cares and communication with the carers. Effective links are established with the DHB and specialty services (eg, mental health, palliative care, geriatrician, wound care).</p> <p>An annual training programme is established with training for registered nurses available from the DHB. Work is currently underway to improve attendance rates for the online in-service training programme (link 1.2.7.5). Outcomes for the service are monitored as per the quality and risk management programme. A corrective action planning process is embedded into practice. Feedback on quality and risk is provided to staff via the various meetings and through graphs and notices.</p> <p>There is a minimum of one RN on the night shift with additional RNs on the am and pm shifts. A</p>

		<p>physiotherapist is available as needed. RNs and healthcare assistants were described by residents and family as being caring.</p> <p>Maternity service</p> <p>The care plans and daily clinical entries in maternity showed informed decision making and consent as well as routine maternal and infant cares. Verbal and written information is current and evidence-based with examples provided (eg, skin to skin, rooming in, breastfeeding, vitamin K, newborn metabolic screening). The daily care plan and clinical entries for both mother and baby provided evidence of staff providing the appropriate standard of care.</p> <p>Clinical staff are supported to attend relevant workshops and online courses to maintain facility-specific and professional requirements.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 20 adverse events reviewed met this requirement when notification was appropriate. Family members interviewed confirmed they are notified following a change of health status of their family member.</p> <p>Three-monthly resident/family meetings provide a venue where issues can be addressed.</p> <p>There is an interpreter policy in place and contact details of interpreters were available. Language and communication needs are used if alternative information and communication methods are available and used where applicable.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Waihi Hospital and Rest Home provides aged care services for up to 51 residents. This includes four primary care inpatient (PCIP) beds for hospital level patients admitted under the care of the GP for up to seven days. The service also has a maternity birthing unit with five beds available. There were 15 hospital level residents and 13 rest home residents in the aged care facility. This included one PCIP resident and one respite resident (rest home level). There were no clients in the birthing unit.</p> <p>The service has been privately owned for the past four years. The owner (non-clinical) visits once a week and is available via phone anytime and email during office hours (Monday – Friday). There is a 2016 - 2017 business plan in place. Documented goals are reviewed a minimum of three monthly. The business and quality plan identifies the values and philosophy of the service.</p> <p>The facility manager is a registered nurse who has been with the provider for nine years and was previously second in charge. She has been in the role of manager for the past year. A job description for the facility manager was sighted and includes management of the maternity annex. The facility manager has</p>

		<p>maintained over eight hours of professional development per annum relating to managing an aged care facility. She receives 16 hours per month of business mentoring by an external consultant.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The facility manager is supported by the second in charge (2IC) who is a registered nurse. The 2IC has been with the service 14 years and covers during the temporary absence of the manager. She was the previous 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>	FA	<p>The previous quality and risk management system is undergoing revision. Interviews with the managers (facility manager and 2IC), and staff (seven care staff, one cleaner, one cook, one maintenance, one laundry, one LMC) reflected staff involvement in quality and risk management processes.</p> <p>The service purchased a new set of policies from an external consultant towards the end of 2016. These policies are still being embedded into practice. Policies are scheduled for regular reviews as per the document control guidelines. These policies and procedures and associated implementation systems, adhere to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Clinical guidelines are in place to assist care staff including InterRAI and pressure injury prevention and management.</p> <p>The quality and risk management programme is designed to monitor contractual and standards compliance and the quality of service delivery. There are guidelines and templates for reporting. The facility has implemented processes to collect and analyse data, which is then utilised for service improvements. Annual resident surveys (2016) have been collated and analysed. An internal audit programme is embedded into practice. Quality data, audit results and corrective action plans are discussed with staff, evidenced in meeting minutes. Corrective actions are signed off when implemented.</p> <p>Health and safety policies are established. A health and safety officer is designated and reports to the staff meeting. The current and previous health and safety officers (three over the past year) have not undergone formal health and safety training (link 1.2.7.5). The hazard register has been updated (19 May 2016) to reflect the current environment. Staff incidents/accidents, and unplanned or untoward events are documented on staff accident/incident forms with feedback to staff in staff meetings.</p> <p>Falls prevention strategies are in place including sensor mats, low beds and intentional rounding. Falls</p>

		<p>assessments are completed for residents identified at risk of falling. A quality goal established for 2017 is to reduce the number of residents' falls.</p>
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. They are signed off by the manager or 2IC when complete.</p> <p>A review of 20 accident/incident forms identified that forms are fully completed and include follow-up by a registered nurse. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are completed for any suspected injury to the head.</p> <p>The facility manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. Section 31 reports were sighted for two adverse events occurring in 2016.</p>
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (three RNs, three healthcare assistants (HCAs), one cook, one cleaner) included a recruitment process (interview process, reference checking, police check), signed employment contracts/collective agreements, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an annual in-service education and training plan that is complimented by an online training programme. There is an attendance register for each training session and an individual staff member record of training. The staff uptake of online training is lower than expected. Performance appraisals were up-to-date in all staff files reviewed of staff who had been employed for one year or longer.</p> <p>Registered nurses are supported to maintain their professional competency. One registered nurse (2IC) has completed their InterRAI training with a second RN in training. InterRAI evaluations are behind schedule. There are implemented competencies for registered nurses including (but not limited to) medication and syringe driver competencies.</p> <p>Maternity Service</p> <p>The client's lead maternity carer (LMC) and her backup midwife attend their labour and birth and/or postnatal daily visits. There are eight HCAs employed in the service and nine contracted LMC midwives. Fifteen staff files reviewed (two RNs and four HCAs and nine contracted LMCs) demonstrated that each</p>

		<p>employee has a signed contract, job description and education records. HCAs provide the daily care provision in the maternity annex. The facility RNs and HCAs receive specific training around their role in supporting mothers and babies.</p> <p>The 'HCAs delivering care to mothers and babies' policy has a clear rationale and is detailed in their role description. The staff files reviewed provided evidence of orientation and relevant education. All healthcare professionals involved in maternity have current ongoing education to support them to practice at the Waihi maternity annexe. There is a detailed education plan for 2017 that incorporates CPR, maternity emergencies and breastfeeding education. The nine contracted LMC midwives have current practising certificates (sighted) and their access agreement contracts meet requirements. Training/education is recorded for individual 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>	PA Low	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale.</p> <p>The rest home unit (occupancy 14 residents) is staffed with an RN three days a week. The hospital unit is staffed with an RN 24 hours a day, seven days a week. The hospital RN covers the rest home when an RN is not available. RNs are supported by adequate numbers of healthcare assistants. There are separate cleaning, laundry and activities staff.</p> <p>Staff were observed 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. Residents and family interviewed also reported there are sufficient staff numbers.</p> <p>Maternity</p> <p>Staffing levels include nine LMC midwives contracted to provide on-call midwifery care for the facility with cover 24/7. There is a contact list provided with the LMC phone numbers for emergency situations. Each client has their own LMC identified (and back-up) who visits daily and is accessible by telephone. HCAs provide the onsite daily postnatal care for eight hour shifts. The RNs in the hospital/rest home are able to answer the maternity emergency bell and provide assistance as needed.</p> <p>The current LMC roster did not have a named midwife for a 24-hour rostered period but does provide a list of on-call LMCs that can be called. This roster does not have a named LMC nominated per 24-hour period. Since previous audit, there has been ongoing discussions and negotiations with the local district health board (DHB), Ministry of Health (MoH) and New Zealand College of Midwives (NZCOM) for this contract requirement and provision of care. All correspondence and meeting minutes were reviewed for this matter on the day of the audit. A review of policy and processes identifies that the service is managing the risk.</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>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24-hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation.</p> <p>A secure storage area stores archived files.</p> <p>Maternity service</p> <p>Waihi maternity has an organised client file documentation system that is maternity focused. The entries are integrated with the LMC entries. Relevant information from other hospitals (eg, postnatal note), are provided and placed into the client notes on transfer. This provides information on progress and planning to date. There are checklists that are completed on a daily basis, which facilitates daily changes to the care plan according to the client and baby needs. The clients are made aware they can request a copy of their maternity notes. All inpatient client files are held and stored in a secure manner. All documentation is carried out in the staff office which the general public do not enter.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements reflect all the contractual requirements. Residents and relatives reported that the admission agreements were discussed with them prior to or on admission. All residents had the appropriate needs assessments prior to admission to the service. The RN ensures that residents are admitted to the service as per contractual requirements.</p> <p>Maternity Service</p> <p>The Waihi maternity service has established assessment processes and clients' needs are fully assessed prior to entry with the LMC and are then identified within the facility documentation booking requirements. There is evidence-based well-developed written information available for clients/families/whānau in the foyer, antenatal waiting room and ward hallway. The LMC and her client discuss her options of 'place of birth' in the antenatal period in relation to her risk factors. Risks are clearly documented and available for in-service staff on entry to the service. Assessments, daily care plans and evaluations are led by the LMC. Risk assessment tools and monitoring forms are available and implemented. Referrals are timely and appropriate for the service and to other services is identified as needed.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>A standard transfer notification form from the district health board is utilised when residents are required to be transferred to the public hospital or to another service. The facility manager verbalised that telephone</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the service.</p> <p>Maternity service</p> <p>All concerns or risks to maternity clients are identified and discussed with all involved. Action plans are developed and regularly updated within the documentation to provide; women centred care, safe and effective treatment while an inpatient, and for when they are planning discharge or transfer. There are clear daily entries in the clients inpatient files identifying any concerns the client or staff have, this is evidenced in the Waihi maternity mother's and baby's care plans reviewed. All plans in relation to discharge or transfer are done in collaboration between the LMC, core staff and the client and her family.</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>	PA Moderate	<p>Rest home and hospital: A sample of 12 medicine records were reviewed. All charts reviewed demonstrated that the resident had been reviewed by the general practitioner within the last three months. All medications are dispensed to the facility by a contracted pharmacy. Unused medicines are returned to the dispensing pharmacy. The storage of medicine was secure. There is a system of medicine reconciliation in use for newly admitted residents. Four rest home residents were self-medicating at the time of audit. All residents have self-medication competencies completed and reviewed by the GP.</p> <p>Medicines are administered by registered nurses in the hospital and by registered nurses and healthcare assistants who had been assessed annually as competent. Registered nurses have completed syringe driver training and there is a close liaison with the hospice for advice and support for palliative care residents.</p> <p>Medication fridge temperatures were being monitored daily and the temperature ranges were within accepted limits and no discrepancies were noted.</p> <p>Maternity service</p> <p>The medicine management systems do not reflect current legislation and guidelines. The service provider's responsibilities are detailed in the policies and procedures. Staff responsible for medication management has attended relevant in-service education and have current annual medication competencies. Individual medication charts were identified in the client notes. The LMC is responsible for prescribing and charting medication required for normal birth and routine postnatal care. Not all prescribing information was recorded in the sample of medication files reviewed. The medicines management policy includes guidelines for client self-administration. Most women who enter the service are well and considered competent to self-medicate. If a woman chooses to self-administer her medicines, this is recorded in her clinical notes and the client has a self-medicating chart to fill in each time she takes medication. Not all files reviewed had a self-medicating chart when it was identified the client had been self-medicating. The emergency guideline for postpartum haemorrhage, which were found in two different folders on the maternity ward, (birth room</p>

		<p>and staff office) both differed in their flow charts of what dosage of medications to give.</p> <p>The facility has a resuscitation trolley in the birthing room and in the medication room next door, there are medicines required for safe birthing and post-natal emergencies. The medicines refrigerator temperature is monitored daily and recorded. Stock and resuscitation trolley medicines are monitored as per the policy. Entonox and oxygen cylinders are regularly checked and are stored in a secure area.</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 are prepared and cooked onsite. There is a four weekly rotating menu which had been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. The service holds an "A" rating food hygiene certificate awarded by Hauraki District Council which expires in June 2017. Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurse or facility manager. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a GP/dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</p> <p>Maternity service</p> <p>Waihi maternity provides mothers and partners (on request) with all meals. All meals are made onsite by the on duty staff. All aspects of food safety are adhered to and there are always hot drinks, fruit, bread, cheese and fresh baking available for mothers. Clients are given different menu choices each day and meals are taken to each woman. Any special needs are identified on entry and people are able to bring food in from home.</p> <p>There is a food handling policy and food storage policy documented as part of the IC guidelines/policies. Any other food the clients request is brought in for mothers by family members/visitors.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where</p>	FA	<p>Rest home and hospital</p> <p>There is a documented policy on decline of entry to the service. The reason for declining service entry to residents to the service would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the resident/family and the appropriate referrer.</p> <p>Maternity Service</p> <p>The LMC and her client discuss her options of 'place of birth' in the antenatal period in relation to her risk factors, the client would be informed if Waihi maternity was not an option to be admitted to or to birth in.</p>

appropriate.		The place of birth booking application is sent to the appropriate level hospital for those women (eg, secondary or tertiary hospital). It is not common for someone to be declined entry to this service as all women are booked in through the established booking system via the LMC which is guided by the section 88 maternity requirements for each level of entry to a hospital. One of the staff interviewed discussed that clients can be declined entry if the facility is full and there are no beds available. This would be discussed with the LMC and they then negotiate entry into another facility for their client. Availability of postnatal beds is stated as a reason for declining transfer for postnatal care only.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	<p>Rest home and hospital: The registered nurses utilise standardised risk assessment tools on admission and the InterRAI assessment tool. InterRAI assessments, assessment notes and summary were in place for all resident files reviewed. The long-term care plans in place reflected the outcome of the assessments. Cultural, sexuality and intimacy needs have been identified for the residents. Registered nurses are competent in the assessment of acute clinical needs of residents to be able to safely deliver care for residents under medical services.</p> <p>Maternity service</p> <p>The LMC midwives that have access to Waihi maternity provide care for women from the booking date at the start of the pregnancy. During the antenatal period, there are extensive assessments of needs, goals and continued planning with all aspects of the maternity experience. There is a Waihi maternity booking form which provides comprehensive entry information for the service. Once the client enters the facility for the labour birth experience or the postnatal period these previous plans form the basis of the care provided while within the facility. All files reviewed confirm the continuum of provision of care with daily assessments, timely interventions, and achievement of planned goals. The tracer file shows needs and daily goals being met in a timely manner.</p>
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	<p>Rest home and hospital: Resident files include all required documentation. The long-term care plan records the resident's problem/need and objectives. Not all resident files sampled had documented interventions to address the residents' needs. Care plans are evaluated for identified issues and were completed six monthly, or in some files as condition changed. Short-term care plans are in use for short-term needs and changes in health status. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Families interviewed confirmed their involvement in the care planning process.</p> <p>Maternity service</p> <p>Continuity of care is provided to the clients by their LMC who visits daily and by the facility HCAs. Inpatient</p>

		<p>orientation to the facility and its services are identified within the daily entries in the facility files while the client is an inpatient. Handover of information between the LMCs and HCAs were evidenced in the five of five files reviewed and show a team approach to the inpatient care.</p> <p>Clients' delivery plans displayed evidence of required support or interventions that were identified as part of the daily ongoing assessment process. Some summary's, topics and updates within the care plans and file were absent. One Waihi maternity client phone interview discussed how she felt that having the same LMC and facility carer over the time she stayed she felt it improved her care and found the information sharing to be consistent. This client said she would highly recommend this service to all her friends and to anyone thinking about coming here.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Residents interviewed confirm care delivery and support by staff is consistent with their expectations. The residents interviewed expressed satisfaction with the clinical care and that they are involved in the care planning. Healthcare assistants interviewed state there is adequate equipment provided including continence and wound care supplies. On the day of the audit, supplies of these products were sighted.</p> <p>There were no pressure injuries being treated at the time of the audit. In the rest home one wound (a skin cancer) was being treated. In the hospital, one surgical wound was currently being treated. Both wounds had a comprehensive wound management plan completed. Wound care was evidenced to be occurring within the prescribed timeframes. The registered nurse interviewed could describe the referral process to a wound specialist or continence nurse.</p> <p>Monitoring occurs for weight, vital signs, blood glucose, restraint, and challenging behaviour.</p> <p>Healthcare assistants interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions at the beginning of each shift.</p> <p>Maternity service</p> <p>The midwifery philosophy of 'Continuity of Care' is provided by the self-employed LMC midwives and core staff that work in and access Waihi maternity. This forms the fundamental basis of the maternity provision of care and it consistently develops to meet the client's needs and desired outcomes throughout the provision of inpatient care. The daily checks ensure that interventions are consistent and provide ongoing assessment of the needs of the woman and her baby. These are well documented in the client progress notes and these notes are also comprehensive and include goals, interventions, referrals and care provided. The maternity services are provided in a timely manner encompassing all education, care provision, decision-making topics and referrals as required.</p>

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	<p>The service employs an activity coordinator to plan and coordinate the individual and group activities programme, which is offered in the rest home and hospital area. The activity coordinator works three days per week. Two volunteers from St. Johns ambulance service and care staff also participate in providing the individual and group activities programme in the absence of the activity coordinator. Each resident had a written and implemented activities programme, which was evaluated and reviewed each time their long-term plan of care was reviewed. A weekly programme was displayed in large print in each area and staff were able to inform residents as to the programme and to direct them to attend the activity of their choice. A daily record of each resident's participation in group and individual activities was maintained. A wide range of activities were included in the programme.</p> <p>Residents were encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. The service has a van that is used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	<p>InterRAI assessments were not evidenced to be reviewed six monthly in two of four resident files who had been with the service longer than six months (link to 1.2.7.5). However, care plan evaluations sampled were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. However, not all short-term care plans reviewed had been evaluated or signed off by an RN when the issue had resolved.</p> <p>Maternity service</p> <p>Daily evaluations were client-focused and orientated to the client's goals and birthing recovery such as: learning breastfeeding techniques, infant bathing, basic hygiene cares, safe sleeping for baby and cord care are ongoing. Evaluations and goal setting continues with their LMC up until six weeks' post-partum when they are then discharged from midwifery care. Unexpected outcomes in any maternity care provided were documented and support was given as required in a professional and timely manner. Referrals have been actioned as needed according to the situation arising. When progress differs from expectation there was documented evidence in clinical records (evidenced in tracer file). Staff contact the LMCs to discuss changes to care provision. Changes to care are initiated by the LMC after discussion with the woman and/or service staff by verbal instruction or by the LMC attending the woman and/or her baby.</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>There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and the families are kept informed of the referrals made by the service. Internal referrals are facilitated by the registered nurses.</p> <p>Maternity service</p> <p>All appropriate options of local supportive health and disability services and providers are discussed and carried out as required or requested such as physiotherapy, occupational therapy, dietitian, social workers. Referrals to external health providers are offered in a timely manner as required, evidenced by information leaflets onsite and in files reviewed. Timely referrals were identified within the tracer file and in the phone interview with the Waihi maternity client.</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>All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use. Product use charts were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided.</p> <p>Maternity service</p> <p>Protective equipment is provided for Waihi maternity staff, visitors and LMCs to use when handling waste or hazardous substances. Equipment sited included plastic disposable aprons, safety masks, glasses, gloves and correct plastic hazard bag receiver (all sited with physical check of facility). Current guidelines are up-to-date and relevant for this facility and include cultural needs. All infectious or hazardous substances are collected in biohazard bags or red lined linen bags. There is a clear process of disposal of the placenta; if the placenta is not kept by the women/family, the placenta is double bagged then disposed of in a yellow infectious waste bag and then disposed of in the hospital boiler. This meets all disposal requirements to protect service providers from harm. Staff interviewed discussed the correct management of the disposal of the placenta.</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</p>	FA	<p>The service displays a current building warrant of fitness. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been maintained with safe paving, outdoor shaded seating, lawn and gardens. Healthcare assistants interviewed confirmed there was adequate equipment to carry out the care according to the resident needs as identified in the care plans.</p>

purpose.		
<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>Some resident rooms include a full ensuite and others share communal toilets and showers. There were sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities were available. Residents interviewed state their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets and showers were well signed and identifiable but did not include vacant/in-use signs. This was addressed on the day.</p> <p>In the rest home, two communal toilets located near six resident rooms do not allow for ease of access when using mobility equipment. However there are four other toilets in the rest home area in close proximity which will accommodate mobility aids (these are located on the other side of the rest home dining room). This building is an old pre-1900 Historic House and the narrow toilets in this area have not been closed as some residents can safely use them and residents with mobility aids are encouraged to use the other toilets.</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>The resident rooms were spacious enough to meet the assessed resident needs. Residents were able to manoeuvre mobility aids around the bed and personal space. Healthcare assistants interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms were personalised. There are a number of four-bedded rooms and all had curtains around each bed to allow for privacy as required. Residents sharing a room interviewed confirmed that they had been asked and consented to sharing.</p> <p>Maternity service</p> <p>There were individual rooms for the mother and baby. Rooms in the maternity unit allowed partners to stay with the mother and baby.</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>There are large lounge/dining areas in the rest home and hospital. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</p>
Standard 1.4.6: Cleaning And	FA	There is a separate laundry area where all linen and personal clothing is laundered by designated laundry

<p>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>		<p>staff. There are designated cleaning staff. There are secure cupboards which store cleaners' trolleys. Staff have attended infection control and safe chemical handling education and there was appropriate protective clothing available. Manufacturer's data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster policies and procedures to guide staff in managing emergencies and disasters (link 1.2.3.3). There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting is in place which is regularly tested. A civil defence kit is in place. Supplies of stored water and food are held onsite and are adequate for three days. A generator is available in the event of a power failure that is checked each month. Electronic call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. The facility is kept locked from dusk to dawn.</p> <p>Maternity service</p> <p>Six-monthly fire evacuation drills are completed. An HCA and registered nurse are onsite at any time a client is in the maternity annexe. The staff have had regular education and training on emergency procedures (eg, neonatal resuscitation and adult CPR certification, fire training), evidenced in all 15 staff education files reviewed. Maternity focused workshops for emergencies are carried out three times a year (eg, post-partum haemorrhage, cord prolapse, unexpected breech and shoulder dystocia). All emergency equipment and security systems are well maintained and in working order.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection</p>	FA	<p>The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the</p>

<p>control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>designated infection control coordinator and has the support of the infection control team. 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. The facility has recently purchased a new quality system and is in the process of transferring information onto the new documents.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse is the infection control coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator and infection control team has good external support from the 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, the infection control team and training and education of staff. The infection control policy manual has recently been purchased by the service from an external quality consultant and the team have been implementing the new documentation.</p>
<p>Standard 3.4: Education</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred (link 1.2.7.5). The infection control</p>

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.		coordinator has completed postgraduate education on infection control. 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.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. 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 management and quality meetings and results posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. There were four (hospital level) residents using enablers (bedrails) and two (hospital level) residents using restraints during the audit. A resident file of a resident using an enabler was reviewed. The resident gave written consent for the use of bedrails. The enabler was linked to the resident's care plan and was regularly reviewed. Online staff training is in place covering restraint minimisation and enablers (link 1.2.7.5).
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	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.

providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by either the RN or the restraint coordinator in partnership with the GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and/or family/whānau is evident. Two residents' files where restraint (two bedrails, one lap belt) was in use were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan, sighted in both residents' files reviewed. An internal restraint audit monitors staff compliance in following restraint procedures.</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify monitoring was evidenced on the monitoring forms for the residents' files reviewed.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly at a minimum. Restraint use is also discussed in the RN meetings, confirmed in the meeting minutes.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the	FA	The restraint minimisation programme is discussed and reviewed. This includes identifying any trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme. A corrective action has been developed to increase attendance for restraint online training (link 1.2.7.5).

monitoring and quality review of their use of restraint.		
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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)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	An education and training programme is established and reviewed annually. Since the previous audit, staff have attended a range of training including (but not limited to) open disclosure, complaints management and food safety (kitchen staff). Individual staff attendance records are maintained. The education and training hours available to staff exceeds eight hours per annum. Only one RN is trained in InterRAI due to staff turnover and the lack of availability of InterRAI training courses. Online in-service training was initiated in 2016. Staff completion rates for mandatory topics are below acceptable limits. A	i) On-line training has not been embedded into practice with low attendance rates. ii) The designated health and safety officer has not attended any formal health and safety training. iii) Cultural training has not been provided for staff. iv) InterRAI assessments are behind schedule due to a lack of RN accessibility to InterRAI training.	i) Ensure staff complete all online education and training topics that are required. ii) Ensure the health and safety officer attends external health and safety training. iii) Ensure cultural

		<p>corrective action plan has been developed around this with a goal of achieving 80% attendance in 2017. Other gaps in education are identified around training for the health and safety officer, InterRAI training, and cultural training.</p>		<p>training is included in the annual education and training plan.</p> <p>iv) Ensure there are adequate numbers of InterRAI trained RNs.</p> <p>180 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Maternity</p> <p>The service provides a staffing skill mix that meets the requirements of primary maternity care provision in this facility. The HCAs provide the facility onsite 24/7 provision of postnatal care and there are contracted LMCs who provide a 24-hour on-call service for emergencies, rapid births and non-booked clients. Missing was evidence of a named midwife for a 24-hour rostered period.</p> <p>The RNs from the hospital and rest home provide emergency care and support to the client and HCAs until a LMC is onsite.</p>	<p>The current LMC roster did not have a named midwife for a 24-hour rostered period but does provide a list of on-call LMCs that can be called starting at the top of the list and working down until a LMC responds. If a HCA fails to get hold of a LMC they would then call 111, as stated in the 'Waihi maternity annex-24 hour midwifery cover' policy statement. The service policy clearly describes the process for accessing on-call midwives. Management stated there has not been a time when the on-call emergency tree has had to be used in the last 14 years. There has not been an instance in this time when they have had a problem contacting a midwife for non-emergency or emergency issues matters.</p>	<p>Ensure the current on-call rostering meets the contract and is approved for Waihi maternity service.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to</p>	PA Moderate	<p>Maternity: There was conflicting information around the standing order for an infusion used to treat postpartum haemorrhage and this was addressed on the day of audit. Eight of ten medication</p>	<p>Maternity: Review of the maternity medication charts showed missing documentation with regards to prescribing, dispensing and documentation requirements as follows;</p> <p>(a) Two of ten medication charts had no allergy noted</p>	<p>Ensure all medications are prescribed correctly including the</p>

manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		charts were evidenced to be fully completed to reflect current legislation and guidelines.	or not; b) Two of 10 medication charts had no designation of prescriber; c) Two of ten medication charts had no frequency of medication prescribed; d) Two of ten medication charts had no route of medication prescribed; e) One of ten medication charts had no specimen signature of prescriber; and f) One of ten medication charts had no dosage of medication prescribed.	noting of allergies, correct dosage, route and frequency of medications and include prescriber's designation and specimen signature. 30 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	Maternity: The facility guideline for medicine management includes instruction for when a client is deemed well enough to self-medicate. Most clients using Waihi maternity are deemed well enough to self-medicate. There is a self-medicating chart for the staff or LMC to document the client's medications, frequency, dose and indication. A discussion with the client ensures the client understands and agrees to self-medicate. This discussion/consent is then documented in the daily clinical entries. Ten self-administration medication charts were reviewed.	Maternity: Review of the maternity medication charts showed missing documentation with regards to prescribing, dispensing and documentation requirements as follows: (a) Two of ten files reviewed did not have a self-medication chart in the client file but it was identified that the client was self-medicating; (b) Two of ten self-medication charts had no strength of medication documented; (c) Two of ten self-medication charts had client identifiers but no medications documented on them, within the clinical notes it was identified they had been self-medicating; (d) Two of ten self-medication charts had no route or frequency of medication documented; (e) Two of ten self-medication charts had no maximum of medication dose that could be taken over a 24 hour period (eg, paracetamol, no more than 8 tablets per 24 hours).	(a-e) Ensure that self-medication charts are fully completed and reflect current legislation and guidelines. 30 days
Criterion 1.3.5.2 Service delivery plans describe the	PA Moderate	Rest home and hospital: Six resident files were reviewed. The initial care plans have been developed within 48 hours of	Rest home and hospital; Two hospital and one rest home resident file did not evidence that care plan interventions provided sufficient detail to guide care	Rest home and hospital: Ensure that

<p>required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>admission. The long-term care plan was developed within three weeks of admission. There was evidence of review in all files however; the long-term interventions do not include sufficient detail to guide staff. Insufficient detail was evidenced in relation to diabetic management, medication management, and management of weight loss in three of six files reviewed.</p> <p>Maternity</p> <p>Five client files were reviewed. All files evidenced that daily updates to postnatal care plan and labour/birth infant summary were not completed.</p>	<p>staff.</p> <p>Maternity</p> <p>Five of five maternity files reviewed; a) did not include a labour/birth and infant summary enclosed; and b) did not identify daily updates to the postnatal care plan.</p>	<p>long-term care plans document sufficient intervention detail relating to diabetes management, medication management and weight loss.</p> <p>Maternity</p> <p>(a-b) Ensure all documentation meets facility and legal requirements. Include dietary requirements to the postnatal care plan.</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and</p>	<p>PA Low</p>	<p>Care staff document in progress notes on every shift. Care plan evaluations are conducted six monthly. Short-term care plans have been developed. Two of six short-term care plans from the sample group evidenced evaluation of progress towards the desired goals and were signed off by a registered nurse when the issues were resolved.</p>	<p>Two of four short-term care plans reviewed did not document evaluation of progress towards the desired goal and two had not been signed off when resolved.</p>	<p>Ensure short-term care plans are evaluated to monitor progress towards the desired goal and are signed</p>

progress towards meeting the desired outcome.				off by a registered nurse when resolved. 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 audit.

No data to display

End of the report.