# Wairiver International Limited - Papakura Private Hospital

## Introduction

This report records the results of a Provisional 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 Audit (NZ) 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Wairiver International Limited

**Premises audited:** Papakura Private Hospital

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

**Dates of audit:** Start date: 5 April 2017 End date: 6 April 2017

**Proposed changes to current services (if any):** No changes have been made to services since the last audit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 40

# 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.

## General overview of the audit

This provisional audit was conducted against the Health and Disability Services Standards and the service contract with the district health board. Papakura Private Hospital provides rest home care and hospital level medical and geriatric care for up to 46 residents with an occupancy of 40 on the days of audit.

The audit processes included a review of policies, procedures, residents and staff files, observations and interviews with residents, family, management, general practitioner and staff as well as a full review of the facility environment and an interview with the prospective provider.

The chief executive officer who is also a registered nurse is responsible for the overall management of the facility with a registered nurse providing clinical oversight.

Improvements are required to medication management, superficial maintenance and emergency processes.

The prospective provider has not previously been involved in provision of aged residential care services. They have familiarised themselves with the Age Related Residential Care Agreement and have been orientated to the needs of the residents at the facility by the chief executive officer and the clinical coordinator. The Counties Manukau Contract Manager has been informed of the proposed change of ownership.

## Consumer rights

Staff have knowledge and understanding of the rights of residents and consumer rights legislation. Services are provided in a manner that includes residents’ rights. The privacy of residents is respected. Residents who identify as Māori have their needs met. The individual values and beliefs of residents are documented and respected by staff. Staff communicate effectively with residents and their families and friends. Open disclosure is practiced. Consent is sought verbally and in writing from residents where appropriate. Residents have access to advocacy services and information on advocacy services is available to residents and relatives. Staff encourage residents to maintain links with their family/whanau and community. There is a documented and recorded system of complaints management in place and implemented.

The prospective provider is familiar with the Health and Disability Code of Consumer Rights and had reviewed the relevant facility policies and procedures.

## Organisational management

There is a documented quality and risk management system in operation. There is an established system of adverse event reporting in place. Relevant corrective and preventive actions are taken. The chief executive officer understands and has instructed the prospective provider in statutory and contractual reporting requirements. Human resource management processes for staff are in accord with current good practice principles and detailed records are maintained. The CEO and the clinical coordinator provide registered nurse cover whether onsite or on call. Staffing levels exceed the minimum requirements specified in the agreement for aged residential rest home and hospital level care. A resident register is maintained and resident information is managed confidentially. Resident files are mainly electronic with some paper-based documents still maintained. Registered nurses are trained to use interRAI software.

The prospective provider has a suitable transition plan for taking over ownership of the facility in approximately six weeks’ time. The current chief executive officer and clinical coordinator will remain in their positions. Current service types, staffing levels and skill mix will be maintained. No changes are proposed to service capacity nor to the service environment. No legislative compliance issues have been identified.

The PP intends to adopt and maintain the current quality plan and management systems.

## Continuum of service delivery

The registered nurses are responsible for the development of care plans with input from the residents, staff and family/whanau representatives. Care plans and assessments are developed and evaluated within the required time frames or when there is any change in resident’s condition.

There are planned activities that are meaningful to the residents, develop and maintain resident’s strengths, skills, resources and interests. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

A medication management system complies with legislation and best practice guidelines for aged care. An improvement is required to ensure that all staff administering medication are assessed as competent. The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. There were no residents self-administering medications.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. The kitchen was observed to be clean, tidy and meets food safety standards.

## Safe and appropriate environment

The facility was established in 1997 and extended in 2005. The building is in good order, has a current building warrant of fitness. Improvement is required to ensure that the emergency evacuation plan is available and displayed in the facility. Monthly and annual environmental checks are maintained. Staff receive annual training in emergency response. There is sufficient appropriate equipment and supplies. Functional and accuracy checks of medical and electrical equipment are done annually.

There are large communal areas for dinning, recreation and relaxation. Fittings and furnishings are well maintained. All bedrooms and ablution areas are suitable for rest home and hospital care. Bedrooms have plenty of natural light. Safe ventilation and heating systems ensure the temperature is maintained within a comfortable range for residents, staff and visitors. Improvement is required to ensure that waste and hazardous substances are safely stored. Cleaning and laundry services are performed onsite by appropriately trained health care assistants. The facility is built around an internal courtyard with additional decks accessible to residents.

## Restraint minimisation and safe practice

There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were seven residents using restraint and no residents using enablers at the time of the audit. Review of residents’ records confirm that assessment, planning, approval, monitoring and review processes are consistently implemented. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing restraint education.

## Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to residents, visitors and service providers. The infection control coordinator is responsible for the surveillance programme, coordinating education and training of staff. Documentation evidences that relevant infection control education is provided as part of staff orientation and as part of the on-going educational programme. Infection data is collated monthly, analysed and reported at staff meetings. Surveillance for infection is carried out as specified in the infection control programme. The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported in a timely manner.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 96 | 1 | 3 | 1 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | Staff receive training in the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights’ (the Code) at orientation and during refresher training. Interviews with staff confirmed they have an understanding of residents’ rights. Staff were observed interacting respectfully and communicating appropriately with residents. Residents are encouraged to make choices. Residents interviewed were able to verify that their rights are upheld by staff. |
| 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 consent. | FA | There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. Staff use verbal consents as part of daily service delivery. Staff interviewed demonstrate an understanding of informed consent processes. Residents confirmed that consent issues are discussed with them on admission and appropriate forms are shown to them at this time and thereafter as relevant. All residents' files reviewed included written consent.  All residents have the choice to make an advance directive and appropriate documentation is held in the resident’s record. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | There are appropriate policies in place and brochures on display regarding advocacy support services. The right to advocacy is explained to the resident and family on admission. Residents interviewed confirm that advocacy support is available to them, if required. Staff interviewed have an understanding of how residents can access advocacy support persons. Two examples of effective involvement of advocates in the complaint process were sighted. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents have access to visitors of their choice at any time of the day and evening. They are supported to access services within the community if they are able to do so and to maintain their links with family and friends. Visitors were seen to be welcomed by staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and procedure refers to the Code and includes timeframes for responding to a complaint. Complaint forms are available at the entrance and in the lounge area of the facility. Residents interviewed know how to make a complaint.  Register of complaints is maintained. Review of associated records confirmed that complaints are managed appropriately in accord with Right 10 of the Code. There have been no complaints received from the Health & Disability Commissioner since the previous audit. There were no concerns that were currently being investigated by external authorities. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and families receive an information pack on admission that includes: the Code; their rights and responsibilities; informed consent; cultural and language support; how to make a complaint; and how to access advocacy. The Code and the complaints process are displayed in communal areas. The admitting registered nurse explains their rights to new residents. Residents interviewed confirm they have access to an independent advocate, if needed.  The prospective providers were interviewed and demonstrated a good understanding of their responsibilities to residents and families. They had familiarised themselves with the HDC Code of Rights and the relevant policies and procedures of Papakura Private Hospital. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff interviewed were aware of the need to respect the privacy of residents and to respect their belongings. Needs and values of residents are documented in the resident’s care plan.  Residents were observed being treated with respect by staff during the audit and the practice was confirmed during interviews of residents.  Staff were observed keeping doors closed while attending to residents. Activities in the community are encouraged where the resident is capable of participating. Staff and family will transport residents to appointments.  Staff receive training in recognizing abuse and neglect. Review of incident records and interviews with residents and staff found no evidence of any suspected or actual abuse and neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | The facility has a cultural safety policy in place. The policy includes guidelines for the provision of culturally safe services for Māori residents. It includes information on cultural awareness, cultural safety, and the importance of whanau.  There are currently a number of residents in the facility who identify as Māori. Cultural preferences are addressed in their plans of care.  Access to Māori support and advocacy services are available from the Nationwide Health and Disability Advocacy Services.  Staff interviewed confirmed an understanding of cultural safety in relation to care. Staff training records confirm that they receive education on cultural safety. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Church services and spiritual support is available as the resident desires. Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are being met. Staff interviewed confirmed an understanding of cultural safety in relation to care. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Expected staff practices are specified in their employment agreements, job descriptions and the staff handbook. Residents interviewed reported that staff maintain appropriate professional boundaries. Staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes. There is a code of conduct and policies in place to guide staff practice. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Training, education and supervision systems are in place to promote good practice by staff to ensure residents receive services of an appropriate standard of care. The chief executive officer (CEO) and the clinical coordinator are committed to ensuring that service provision is based on best practice and access clinical nurse specialists and district health board specialists as necessary. The policies in use include references to evidence-based research. References to additional documents are included in policies as appropriate. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy and associated procedure is in place to ensure staff maintain open communication with residents and their families. Communication with family members is documented in residents' records. Incident forms record evidence of communication with the family following adverse events. The CEO and the clinical coordinator are aware of situations that require notification to external agencies. Residents interviewed confirmed that staff communicate well with them. Interpreting services are contacted if required to ensure that communications are understood. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Papakura Private Hospital is a privately owned and operated residential care facility. The CEO is a registered nurse and is responsible for the operation of the facility. Another experienced registered nurse is responsible for clinical standards and coordination of services. The owners and the CEO meet monthly to review and plan services.  The facility holds three agreements with Counties Manukau District Health Board (CMDHB) for the provision of publicly funded residential services. One is the aged related residential care services agreement for up to six residents requiring rest home care, one for hospital level care for up to forty residents, one for residents under 65years and one long-term support-chronic health conditions agreement (LTS-CHC). A further agreement is held with the Accident Compensation Corporation for rehabilitation care for people recovering from injury. The prospective provider’s (PPs) had copies of these contracts and had discussed them with the current owners.  On the day of audit there were 46 beds available which were occupied by 40 residents. Thirty eight were subsidised hospital care, one was a subsidised rest home resident, three residents were receiving care under the LTS-CHC agreement and one was an ACC resident. Seven of the residents were under 65 years of age.  There is a documented quality management plan in place which includes the direction, vision, and mission statement, scope of services, objectives and action plans. There is also a risk management plan that is developed by the CEO in consultation with staff. Both plans are reviewed annually by the owners and management. The CEO monitors progress against the plans and keeps the owners and the staff informed.  The PPs have familiarised themselves with these two documents. Through interview the PPs demonstrated understanding of the basics of quality and risk management and stated that they intend to adopt and maintain the current quality and risk management plans and systems.  There is a documented transition plan with time lines for changeover of ownership. The CMDHB contract manager has been informed of the intended change of ownership.  The CEO has a background in aged care services including psychogeriatric care and has been at the facility since 1990.The CEO has completed eight hours plus of education per annum by attending relevant seminars and conferences. The PPs intend the current CEO to continue to manage the service.  The clinical coordinator is a registered nurse who has responsibility for the oversight of all clinical care and reports to the CEO. The CEO and the clinical coordinator both work full time and share the on-call services. Both registered nurses have training relevant to aged care. The clinical coordinator has completed at least eight hours of professional development in the previous year. |
| Standard 1.2.2: Service Management  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. | FA | The daily operation of the service is managed by the CEO. The clinical coordinator is responsible for clinical care and supervision of staff. There are systems in place to ensure the day-to-day operation of the services continue if the CEO is absent. In this situation the clinical coordinator steps into the CEO management role and a senior registered nurse coordinates the clinical services. The PPs intend to maintain the current arrangements for service management. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service implements documented policies and procedures to support service delivery. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, contracts, and evidenced-based best practice guidelines. Policies and procedures reference interRAI and the changes in health and safety legislation. The clinical coordinator participates in development and review of clinical policies. There is a formal document control process in place. Documents are reviewed annually or earlier when required. Outdated policies are archived on site.  The policies around wounds have been updated to include information provided by the Ministry of Health regarding pressure injuries. A monitoring and reporting system has been developed and implemented for Stage One pressure injuries to prevent progression to Stage Two injury. This has resulted in no incidence of Grade Two injuries in the last twelve months. There is one Stage Three pressure injury that was acquired prior to admission to the facility.  The quality and risk management systems include quality improvements, risk and hazard management, resident satisfaction including complaints management, management of incidents and accidents, health and safety management, infection prevention and control, and restraint management. Resident and family satisfaction surveys express satisfaction with service delivery.  Quality improvement data are collected by the CEO who analyses and graphs the data and evaluates the findings. Results are communicated to the owners/management and to staff at respective monthly quality meetings. Minutes are available for those staff who do not attend the meetings.  An internal audit programme is implemented by the CEO and records are maintained and used to improve services. Corrective action plans are developed to address any deficits. The effectiveness of remedial actions is verified and signed off by the CEO. Records indicate that internal audits have been completed since the last surveillance audit in accord with the schedule in the annual internal auditing programme.  Health and safety policies and procedures are documented along with the hazard management programme. These policies have been revised since the changes in health and safety legislation. There is a hazard register in place. There is evidence of hazard identification forms being completed when a hazard is identified. Hazards are eliminated, minimised or isolated. Health and safety matters are discussed at the quality meeting. |
| 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 | The CEO and the clinical coordinator are aware of situations where there is a need to notify statutory authorities and where HealthCERT would need to be notified of a Section 31 adverse event. There have been no such events at the facility since the previous surveillance audit.  Staff document adverse, unplanned, or untoward events in order to identify opportunities to improve service delivery, and to identify and manage risk. A register is maintained. Review of associated records of incidents and accidents for the last 12 months indicated that adverse events are recorded and managed in accord with the documented procedure. The CEO collates a monthly summary of adverse events which is discussed at staff meetings.  There have been no legislative compliance issues identified. |
| 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. | FA | There are policies and procedures in relation to human resource management that meet legislative requirements. A review of thirteen staff records was conducted, which included samples from all staff groups of staff. Each record contained recruitment documentation, reference checks, evidence of police vetting, an employment agreement, a job description, evidence of qualifications, orientation records, and evidence of annual performance appraisals. Professional qualifications are checked by the administration manager. Registered health professionals providing services including the five general practitioners, the physiotherapist, occupational therapist, podiatrist, mobile radiologist and phlebologist had current practising certificates. No volunteers or agency staff are used.  The clinical coordinator is an approved interRAI assessor and is aware of the need to meet annual obligations for maintaining competency. Three registered nurses have completed interRAI training. The CEO is responsible for management of the in-service education programme. There is an in-service training planner in place, which outlines proposed and actual training provided. Training required by the Aged Residential Care contract is provided and mandatory training is identified. Records of training sessions and individual training are maintained. Attendance is recorded.  Staff receive performance appraisals annually or earlier if required. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a roster policy that defines the staff cover for registered nurses, healthcare assistants and household staff. The rostering practice was reviewed. The rosters sighted showed that the service meets and exceeds minimum staffing requirements as outlined in the Agreement. Roster changes are recorded.  There is always at least one registered nurse on duty. The CEO and the clinical coordinator are onsite five days a week and alternately on call after hours. There are activities staff on duty daily. A physiotherapist is on site two half days a week and trained healthcare assistants maintain the programs seven days a week. A podiatrist is available by appointment. Kitchen, cleaning, laundry and maintenance staff are employed by the facility and receive appropriate orientation and on-going training. No volunteers or agency staff are engaged. Residents state that there are sufficient staff to support them over the 24 hours seven days a week.  The PPs are aware of ARRC requirements regarding staffing and intend to adopt and maintain the policies of the current owners regarding staff numbers and skill mix. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The electronic patient management system was installed in 2014. Subsequent evaluation has confirmed it an effective and timely system for management of resident information. All entries are legible, dated and timed, and identified to the provider. Laptops and tablets are used by all staff (including the doctor and therapists) to record resident care and events as they occur. The doctor can access the residents’ medical notes when off site. This has enabled access to real time resident information for all staff and resulted in improved patient outcomes.  A resident register is maintained in hard copy. The registered nurse enters resident's data into an electronic spreadsheet on the day of admission to the facility. InterRAI information is recorded accurately in the interRAI software programme. Residents' information is protected by individual electronic password. Personal information is not on public display.  Historical records are paper based and are held on site in locked cupboards. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry to services policy includes all the required aspects on the management of enquiries and entry. Papakura Private Hospital’s welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate and local communities and referral agencies. Admission requirements are conducted within the required time frames and were signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The standard transfer form notification from the district health board is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident’s records to confirm this. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | There is a documented policy for the management of the medication system. The organisation uses an electronic system for e-prescribing, ordering, dispensing and administration of medication. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated and photos uploaded for easy identification. The RN was observed administering medication correctly. Medication reconciliation is conducted by the RNs when a resident is transferred back to service.  The service uses pharmacy pre-packed plastic packs that are checked by the RNs on delivery. The controlled drug register is current and correct. Weekly and six monthly stock takes are conducted and all medications are stored appropriately. There were no residents self-administering medication at the time of the audit. There is a policy and procedure for self-administration of medication if required. An annual medication competency is completed for all staff administering medications and medication training records were sighted. An improvement is required for practical assessments to be conducted as part of the medication competency programme. The medicines management system complies with legislation, protocols and guidelines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The meals are prepared on site and served in the respective dining areas. The menu is currently being reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The nutritional needs are provided in line with recognised nutritional guidelines appropriate to the residents at the service. A client food preference sheet is developed on admission which identifies dietary requirements, likes and dislikes. Supplements are provided to residents with identified weight loss issues.  The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring food, fridges, freezers and chiller are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.  The meal service audit and satisfaction survey conducted in November 2016, indicated that residents/family are happy with the meals provided and any other adjustment will be made accordingly. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The clinical coordinator who is a registered nurse reported that whenever a consumer is declined entry family/whanau are informed of the reason for this and other options or alternative services available and this is indicated on the client admission enquiry details form. The consumer is referred to the referral agency to ensure that the consumer will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial assessments are completed within the required time frame on admission while care plans are completed within three weeks. Assessments and care plans are detailed and include input from the residents, family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews, the family/whanau expressed satisfaction with the support provided. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Long term care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short term care plans for short term problems. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. The residents and family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in short term care plans and long term care plans are adequate to address the residents’ assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed and the staff confirmed they have access to enough supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support they are receiving. |
| 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 | The planned activities are meaningful to the residents’ needs and abilities at Papakura Private Hospital. The activities programme covers physical, social, recreational, spiritual, intellectual emotional and cultural needs of the residents. The activities coordinator reported that they ascertain the resident’s response and interest during activities and modify activities accordingly with oversight from the clinical coordinator. The activities are modified as per capability and cognitive abilities of the residents. The activities coordinator develops an activity planner which is posted on the respective notice boards. Activities are provided for all residents’ in rest home, hospital and under 65 years of age. Residents’ electronic files have a documented activity plan that reflects their preferred activities of choice. Over the course of the audit residents were observed engaging in a variety of activities. The residents and family/whanau reported general satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long term care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Residents where appropriate, family/whanau and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and noted when the short term problem has resolved. The required evaluations were sighted in resident’s electronic records sampled. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | There is a documented process for the management of all referrals. The service utilise a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are documented processes for the management of waste and hazardous substances in place. Policies and procedures provide guidance for staff. Material safety data sheets are available. Staff receive training and education on safe and appropriate handling of waste and hazardous substances, including chemical safety. The credentials of the waste removal contractor were sighted. It was observed that some chemical cleaners were not always securely stored. This was remedied during the audit.  Suitable secure facilities are available for the disposal of waste and hazardous substances. Protective clothing is available to and used by staff. . |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | Papakura Private Hospital is a single storey building of three wings. The facility can accommodate up to 46 residents in single rooms of sufficient size for rest home and hospital care. A current building warrant of fitness is displayed, which expires 28 July 2017. There have been no building modifications since the last audit. Records of monthly inspections are maintained. The PPs stated on interview that they have no immediate plans for any changes to the building or it’s environment.  The building is well maintained. Maintenance is either done by staff or external contractors. There is a reactive maintenance system in place, which is managed by the CEO.  Sufficient suitable monitoring and medical equipment is available to meet the needs of residents. Functional tests and calibrations are up to date. Weighing scales are suitable for both standing and seated residents. All electrical items are tested and tagged by a contractor. The credentials of the technicians were sighted. Staff interviewed confirmed they have adequate access to equipment.  Hot water temperatures in resident areas are recorded by the cook and by the team leader monthly. Records reviewed indicated that temperature testing was within the accepted temperature ranges for the provision of care to vulnerable residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Thirteen bedrooms have full ensuites. The remainder have hand basins with close access to seven communal toilets. A shower trolley and three large shower rooms are available. Bathrooms are ventilated and heated. There are separate toilets for use by staff and visitors. All bathrooms have occupancy signs.  The fixtures, fittings, floors and wall surfaces are in good condition and constructed from materials that can be easily cleaned. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Bedrooms are of single accommodation. Eight of the single bedrooms can be joined to form four double rooms if required. Bedrooms allow use of hoists and other mobility aids and provide adequate personal space to move around within the room safely. Residents’ bedrooms are personalised to varying degrees. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are large communal areas for dinning, recreation and relaxation that can accommodate all the residents at once. There is sufficient seating of a variety of styles to meet all needs. There is ample room for wheelchairs and lazy boy armchairs. Staff reported that all residents are encouraged to eat in the dining room but some prefer to eat in their rooms. The group activities programme is provided in the lounge area. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Suitable cleaning and laundry policies and procedures are available to staff.  Laundry is performed by a permanent laundry person and assistant seven days a week. Collection bags are covered and collected regularly. All linen is washed on site in a purpose designed laundry room. Personal laundry and ironing is done separately by the laundry person. There is good separation of clean and dirty flow in place in the laundry. Laundry chemicals are held in a closed system and dispensed automatically directly into the washing machines. Washing and drying machine temperatures are monitored and records maintained.  There are permanent cleaning staff on duty seven days a week. Cleaning equipment, cupboards and trolleys are secure and well stocked. A suitable cleaning schedule is documented and maintained. The facility was fresh, clean and tidy during the audit.  The effectiveness of the cleaning and laundry services is monitored on an ongoing basis by the CEO and is included in the internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | An email notification of approval of an evacuation scheme was sighted but the evacuation plan was unable to be located by the CEO on the day of audit. Previous audit documentation referenced an approved evacuation plan. An evacuation plan was drawn up and posted at fire points during the audit. Fire points and exits are clearly indicated. Staff interviewed are aware of evacuation procedures.  Trial evacuations are held twice a year, last done on 17-Aug-16 and 29-Feb-17. Staff records sampled provide evidence of attendance at fire safety training.  Documented policies are in place for emergency management. Emergency and security education is provided to staff during their orientation and during refresher training. Processes are in place to meet the requirements for emergency management.  There is emergency equipment available. The site has only one source of power, which is electricity. There is no generator on site. he manager stated there is an arrangement with a neighbouring rest home for any assistance required in an emergency. There is a gas barbeque for cooking and for heating water. The service has large torches, a telephone connected to a land line, first aid supplies, radio, extra blankets and extra food supplies. Additional pandemic supplies are held on site. The facility carries sufficient clean water for three days use in an emergency if the water supply was disrupted.  The call bell system is electric. Call bells are provided in every bedroom and bathroom. The bell cord was either missing or tied up in two bathrooms. Call bell indicator panels are located at the nurses’ station and at the end of the main hallway. Staff use the indicator panel to advise them where a bell is ringing. An electronic record is maintained and monitored by the CEO. Smoke detectors and a fire sprinkler system are in place and records of monthly checks were sighted.  There is a security lock down process implemented by staff in the evenings and overnight. Staff carry personal alarms in the evening and at night that can alert a colleague to the need for assistance. External automatic lighting is installed. A security company is on call if required. |
| 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. | FA | All designated areas used by residents have an external window for natural light. Some have doors onto external decks. Ventilation is provided by opening windows and doors. The facility uses electricity for heating which can be controlled at individual wall radiators. Wall radiators have screens to prevent burns. |
| Standard 3.1: Infection control management  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. | FA | Papakura Private Hospital provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The clinical coordinator is the infection control coordinator (ICC) and has access to external specialist advice from the GPs’ and district health board and infection control specialists when required. The infection control programme at Papakura Private Hospital allows for a systematic, coordinated and ongoing approach.  The infection control programme is reviewed annually and is incorporated in the monthly meetings and review of the education programme. Staff are made aware of new infections through daily handovers on each shift and by progress notes. The infection control programme is appropriate for the size and complexity of the service. Infection control practices are guided by infection control policies and procedures. Interview conducted with the ICC indicated that all infections are monitored through a surveillance system in accordance with the infection control programme. There are processes in place to isolate infectious residents when required.  A documented job description for the ICC including role and responsibilities is in place. Hand sanitisers and gels are available for residents, staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC is responsible for implementing the infection control programme and indicated there is adequate human, physical, and information resources to implement the infection control programme. Infection control reports are discussed at the management and monthly staff meetings, or as when necessary. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| Standard 3.3: Policies and procedures  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. | FA | Papakura Private Hospital has documented policies and procedures in place that reflect current best practice. The CEO is responsible for infection prevention and control and has completed relevant infection prevention and control education. Staff were observed to be following the infection control standards that comply with relevant legislation and current good practice. Staff demonstrated knowledge on the requirements of standard precautions and are able to locate policies and procedures. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The ICC is a registered nurse and provides infection control education to staff during orientation and the annual education program. Training sessions are documented and attendance records completed. The ICC has access to external specialist advice from the GPs’, DHB and infection control specialists when required. In interviews conducted, staff affirmed an understanding of how to implement infection prevention and control activities during their practice. |
| 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 | The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Minutes of meetings and education records were sighted. An external consultancy firm has provided tools to enable monthly analysis of infections comparing with other health care providers. The GP is informed within the required time frame to prescribe antibiotics if any resident has an infection. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Papakura Private Hospital aim to minimise the use of restraint through completing falls risk assessment forms and use of call bell system. An updated restraint register was sighted and staff interviewed understand the difference between restraint and enablers. Risk minimisation is documented in the care plans of the residents and restraint is evaluated regularly. Approved equipment which can be used as a restraint includes; bedrails; fallout chairs; low beds. There are currently seven residents on restraint for safety and no residents using enablers for safety and comfort. The family and residents are fully informed about the restraint process and risks involved. |
| 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 coordinator is the designated restraint coordinator and is responsible for education of staff ensuring the restraint process is followed according to restraint minimisation and safe practice standards. The roles and responsibilities of the restraint coordinator are clearly defined and there are clear lines of accountability for restraint use. The approval process is in place and includes: the clinical coordinator; GP; resident and family member.  Approved equipment which can be used as restraint includes bedrails, fallout chairs, low beds. There are currently seven residents on restraint for safety and comfort and no resident using enablers. Restraint use is discussed in management and staff meetings. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint coordinator completes restraint assessment forms for residents who demonstrate that the use of restraint is indicated. There is evidence in the electronic files of the residents on restraint, that risk factors are identified in the assessments and the purpose of the chosen restraint are clearly documented. The implementation of restraint for the resident is linked to their care plan. Interviewed staff members demonstrated understanding in maintaining culturally safe practice. Consent for the use of restraint is provided by the GP, coordinator, resident and family/whanau. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A current updated register was sighted. The long term care plans have documented risk management plans required to ensure residents’ safety while using restraint. The service has an approval process as part of the restraint minimisation policies and procedures that are applicable to the service and accessible to staff to read. Restraint authorisation is in consultation with resident, family/whanau, restraint coordinator and GP. The approval process ensures the environment is appropriate and safe. Restraint use is reviewed at least three monthly and six monthly and as part of restraint register reviews. Staff interviewed demonstrated understanding about restraints and strategies to promote safe practice.  The restraint monitoring and observation process is included in the restraint policy. There were no restraint related injuries reported. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Regular reviews are conducted on residents and this was evident in the records sampled. The GP confirmed involvement in the restraint review process. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring and any change required. Interviewed staff and family/whanau confirmed involvement in restraint use evaluations. The evaluation forms included the effectiveness of the restraint in use and the risk management plans documentation in the long term care plans. Evaluations time frames are determined by the risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service has demonstrated monitoring and quality review on the use of restraints. Restraint updates are included in the monthly staff and periodic quality control meetings. Individual approved restraints are evaluated three to six monthly through a restraint meeting and as part of the facility approval team review with family/whanau involvement. Meeting minutes confirmed discussions on restraint are being conducted and included review of restraint use. The clinical coordinator reported that assessments and monitoring are appropriate. Policies and procedures are up to date and a training record was sighted and annual reviews are done. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | Staff administering medication are assessed as competent. Annual medication competencies are conducted in form of questionnaires and training records were sighted, however there was no evidence of practical medication competencies records sighted for all staff. | Practical medication competencies of staff administering medication were not verified. | Ensure practical medication assessments are included in the annual competency programme.  180 days |
| Criterion 1.4.1.1  Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Negligible | Cleaning chemicals are delivered via an in-line bulk system that is secured in the locked cleaners cupboards. Chemicals on cleaners trolleys are in labelled disoensers with screw-on lids or spray tops. It was observed during the audit that –  There are chemical cleaners are stored on shelves in the sluice room by the nurses’ station. The room is not secured and can be entered by residents.  There are chemical cleaners and air fresheners stored on open shelves and windows sills in resident bathrooms.  . | Chemical cleaners are not always stored securely from residents and visiting children. | A slide bolt was attached to the sluice room door and all cleaners were removed from residents’ bathrooms during the audit.  No further action required.  1 days |
| Criterion 1.4.2.6  Consumers are provided with safe and accessible external areas that meet their needs. | PA Moderate | There is an internal open courtyard with umbrellas and seating. A designated smoking area is provided in a side garden area. The front garden includes a ramped walkway with handrails. Decks to the side and rear of the building have handrails but the stairway access is open and residents could fall down the stairs. | There are no safety gates at the top of the stairs on the side deck nor at the deck by the back door of Ward 2. | Provide safety gates at the top of the stairs off the external decks.  30 days |
| Criterion 1.4.7.3  Where required by legislation there is an approved evacuation plan. | PA Low | An email notification of approval of an evacuation scheme was sighted but the evacuation plan was unable to be located by the CEO on the day of audit. | The approved evacuation scheme was not available. | Display the approved evacuation scheme at key points throughout the building  7 days |
| Criterion 1.4.7.5  An appropriate 'call system' is available to summon assistance when required. | PA Low | The bell cord was either missing or tied up in two of the bathrooms. | Call bells are not maintained in two of the bathrooms. This was remedied during the audit. | Maintain resident call bell cords in usable condition.  7 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.