# Whangaroa Health Services Trust - Whangaroa Health Services

## 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](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:** Whangaroa Health Services Trust

**Premises audited:** Whangaroa Health Services

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

**Dates of audit:** Start date: 20 March 2017 End date: 21 March 2017

**Proposed changes to current services (if any):** This audit included assessing two additional rooms as suitable for dual purpose use.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 23

# 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 |
|  | 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

Whangaroa Health Services Trust operates a community owned primary health care service and an aged residential care service. The Kauri Lodge aged care service has 24 beds and provides rest home and hospital (geriatric and medical) level care. On the day of the audit there were 23 residents. The trust board employs a chief executive officer, a cultural and compliance manager, human resources manager and clinical manager to implement the strategic plan and oversee the day-to-day operations of all services.

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

This audit included verifying two additional rooms as suitable for dual purpose use.

This audit has identified improvements required around complaints management, quality improvement data, corrective actions, human resources management, interventions, medication management, food service and infection control.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

The staff at Whangaroa Health Services Trust ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent and advanced directives are documented. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. Appropriate employment processes are adhered to. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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

Residents are screened and approved prior to entry to the service. There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrated service integration and were reviewed at least six-monthly. Resident files included medical notes by the contracted GP and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for the administration of medicines complete education and medication competencies. Medication charts are reviewed three-monthly by the general practitioner.

The activities team implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations. Residents and families report satisfaction with the activities programme.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

## 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. |

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. Some residents’ rooms have ensuites and there are sufficient communal showers/toilets for the others. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The facility has a no or minimal restraint use philosophy. There is a restraint ‘champion’ and restraint and safe practice policies and procedures are in place. There are currently two restraints in use. Residents using restraint are closely monitored and any risks are documented. Consent for use of restraint is obtained from the resident or EPOA. Staff restraint education is completed annually.

## Infection prevention and control

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of low risk. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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 | 43 | 0 | 7 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 8 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (five caregivers, two registered nurses (RN), one diversional therapist, one chief executive officer, a cultural and compliance manager and clinical manager) confirm their familiarity with the Code. Interviews with seven residents (five rest home and two hospital) and three families (two rest home and one hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings. |
| 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 | The service has in place a policy for informed consent and resuscitation. Completed resuscitation forms were evident on all resident files reviewed. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed with the admission agreements. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information and their contact details is available in the entrance foyer and in other places around the facility. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate. |
| 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 are encouraged to be involved in community activities and maintain family and friend networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The service has a complaints policy that describes the management of complaints process. There is a complaint form available. Information about complaints is provided on admission. Interviews with residents demonstrated an understanding of the complaints process. All staff interviewed could describe the process around reporting complaints.  There is a complaint register (sighted). The CEO (interviewed) advised that verbal and written complaints are documented. There have been three complaints received since the previous audit. The complaint documentation was reviewed. Not all complaints have been responded to within the required timeframes. The complaints have been investigated by the service and corrective actions have been put in place.  One complaint has been referred by the complainant to the DHB. The DHB have completed an investigation into this complaint and provided Whangaroa with a copy of their complaint investigation report on the 10 March 2017. The CEO advised that the service will now develop and implement the corrective actions required.  Discussions with residents and families during the audit confirmed that any issues are addressed and they feel comfortable to bring up any concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well-informed about the Code. Resident meetings and a resident and family survey provide the opportunity to raise concerns. Advocacy and Code of Rights information is included in the information pack and are available. |
| 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 could describe the procedures for maintaining confidentiality of resident records, resident’s privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment.  Church services are held bi-weekly and resident files include cultural and spiritual values. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided (April 2016). |
| 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 service has a Māori heath plan which includes cultural safety and awareness. The service has a strong Kaupapa focus with 30% of residents and 70 % of staff identifying as Māori. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Cultural needs and links are clearly documented in the care plan. The service has established links with local Māori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety.  Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and reviewed, as demonstrated in resident files sampled. Discussions with staff confirm that they are aware of the need to respond to cultural differences. |
| 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 | The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.  Information gathered during assessment including resident’s cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness (October 2016). |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey completed in July 2016 reflected high levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Nine incidents/accidents forms were reviewed. The forms include a section to record family notification. All forms sampled indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member’s health status. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Whangaroa Health Services is governed by a trust board, comprised of representatives from the local community. The service provides care in Kauri Lodge for up to 24 residents at hospital and rest home level care. On the day of the audit, there were 23 residents. In the 10-bed rest home wing, there were 10 rest home residents. In the 14 dual purpose beds, there were 3 rest home and 10 hospital level residents. There was one hospital resident admitted on a respite contract and one rest home resident admitted under an ACC contract. All other residents were under the ARRC contract.  This certification audit included assessing an additional two dual-purpose beds. The two new rooms have sufficient space and are suitable for the provision of rest home and hospital level care. This has increased the dual-purpose beds from 12 to 14.  The service is managed by a CEO who is a trained social worker with a law degree and has been in the role since February 2015. The CEO is supported by a finance manager, a cultural and compliance manager and a clinical manager (registered nurse). The clinical manager (CM) has been in the position since October 2015. The CEO provides a monthly service management report to the board.  An annual business plan has been developed that includes a philosophy, values and measurable goals. The business planning year is from June to June. The goals in the business plan for 2016-2017 have been achieved and progress against the achievement of these goals has been regularly reported to the board.  The CEO and clinical manager have completed at least eight hours of professional development activities related to managing a rest home and hospital. |
| 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 clinical manager and the cultural and compliance manager provide cover during a temporary absence of the CEO. |
| 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. | PA Low | A quality and risk management programme is in place. Interviews with the CEO, clinical manager, cultural and compliance manager and care staff, reflected an understanding of the quality and risk management systems that have been put into place.  Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to interRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.  A continuous quality improvement team (CQI) has been established. The team is made up of ‘champions’ within the following key clinical areas: falls prevention, infection control, continence, pressure injuries, medicines and wound care. The current ‘champions’ are new to these roles because of recent changes in staff. The registered nurses are currently being mentored into the roles by the clinical manager. The CQI team meet monthly and are committed to providing high quality care and services to each resident and their family/whānau.  Quality data is collected for (but not limited to): falls, skin tears, challenging behaviours, infections, wounds, accidents and incidents and pressure injuries. The internal data is collated monthly and communicated to staff at the monthly meetings. The internal quality data is not consistently analysed or trended.  The service participates in a benchmarking data group with four other facilities in the Far North. Corrective actions are not consistently documented where the external benchmark data for Whangaroa identifies opportunities for improvements.  An internal audit schedule is in place but has not been fully implemented. Where areas for improvements are identified, corrective action plans are not consistently documented or reviewed and signed off once completed. There was evidence in the monthly staff meetings to verify staff are informed of audit results and corrective actions.  Examples of quality improvements since the last audit included (but were not limited to): improving ramp access, installing a digital generator, updating the emergency lighting and converting two- unused rooms to dual purpose bedrooms).  A health and safety programme is in place. An interview with the health and safety officer (CEO) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility’s health and safety programme. The hazard register is reviewed annually and was last reviewed in May 2016.  Falls prevention strategies are implemented for individual residents.  Resident/relative meetings have been held monthly. A resident satisfaction survey was completed in July 2016. There was an 87% return rate with residents reporting a high level of satisfaction with the service. |
| 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 | An accidents and incidents reporting policy is in place. There was evidence to support actions are undertaken to minimise the number of incidents. Clinical evaluation of residents following an adverse event is conducted by a registered nurse and was evidenced in all eight accident/incident forms selected for review (link 1.3.6.1).  Adverse events are linked to the quality and risk management programme. Staff are kept informed in a timely manner regarding accidents and incidents.  The CEO, cultural and compliance manager and the clinical manager are aware of the requirement to notify relevant authorities in relation to essential notifications. |
| 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 | There are human resources management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed (one CEO, one clinical manager, one registered nurse, one caregiver, one cook and one cleaner) and evidence that reference checks were completed before employment was evidenced. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed could describe the orientation process and stated that they believed new staff were adequately orientated to the service.  The in-service education programme for 2016 and the education programmes for 2017 (year to date) have not been fully implemented. The clinical manager and registered nurses are able to attend external training. The service has recently implemented access to online learning for staff. One of six registered nurses have completed interRAI training. Staff appraisals were not evident in all staff files reviewed. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Whangaroa Health Care has a two-weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. In addition to the clinical services manager (a registered nurse), who works full-time, there is one registered nurse rostered on each shift. On a morning shift, there are four caregivers, one of which is on a six-hour shift. On an afternoon shift there are three caregivers, two of which finish at 2100hrs. On nights, there is one caregiver.  The staff interviewed advised that additional staff can be rostered on to meet the needs of the residents.  Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident 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. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant caregiver or registered nurse. |
| 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 | There are policies and procedures to safely guide service provision and entry to services including an admission policy.  The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Four out of five admission agreements viewed were signed and dated. One is still being processed. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. Respite residents have their discharge recorded in the progress notes. |
| 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 are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were two residents self-administering on the day of audit. Both residents had been assessed as competent to self-medicate and had signed consent forms.  The facility uses a medico pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses who have passed their medication competency administer medications. Medication competencies are updated annually and staff attend annual education. There are no standing orders. The medication fridge temperature is checked daily. Eye drops are dated once opened.  Staff sign for the administration of medications on medication administration sheets. Controlled drugs are checked out by two people. The DDA register is checked weekly.  Ten medication charts were reviewed. Medications have been reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. ‘As required’ medications did not all have indications for use charted. |
| 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. | PA Low | The service employs two cooks, one Monday to Friday and one at the weekend. There are no kitchen hands. Both have current food safety certificates. The week day cook oversees the procurement of the food and management of the kitchen. There is a well equipped kitchen and all meals are cooked on-site. Meals are served directly from a bain marie to both dining rooms. Special equipment such as lipped plates are available. On the day of audit, meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked at the lunchtime meal only. These were all within safe limits. The evening meal is left by the cook to be reheated by the caregivers; food temperatures are not checked. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents’ dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a kitchen whiteboard. The four-weekly menu cycle is written and approved by an external dietitian. All but one resident/family interviewed were very happy with the meals provided. The resident who wasn’t completely happy would like more ‘boil ups’; these are already on the menu. There were bowls of fruit available in the dining room for residents to help themselves. |
| 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 service records the reason for declining service entry to residents, should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six-monthly or when there was a change to a resident’s health condition. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all long-term residents. Care plans sampled were developed on the basis of these assessments |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs but lacked sufficient detail to guide care (link1.3.6.1). Residents interviewed stated that they were involved in the care planning process.  Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, physiotherapist, dietitian and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident’s condition changes, the RN will initiate a GP consultation. Staff state that they notify family members about any changes in their relative’s health status. Five of five care plans sampled had interventions documented but these lacked sufficient detail to guide care. Care plans had been updated as residents’ needs changed.  Resident falls are reported on accident forms and written in the progress notes. The facility’s falls policy states that for all unwitnessed falls, residents must have neurological observations completed. This has not always been completed.  Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted.  Wound assessment, wound management and evaluation forms are in place for all wounds. Implementation of wound care plans were not always signed off as completed. Wound monitoring occurred as planned. There are currently seven wounds (two lesions, three skin tears and two chronic venous ulcers). There were photos of all wounds. The facility has access to wound care specialist advice if required.  Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. |
| 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 | There is one diversional therapist (DT) who works 24 hours a week. On the days of audit, the diversional therapist was involved in a regional diversional therapist meeting but came in to be interviewed. Caregivers were observed talking with residents and some residents were watching a television quiz. In the afternoon, many of the residents were at the hairdressers.  There is a large whiteboard in the hallway and the monthly programme is on this. Residents have the choice of a variety of activities in which to participate. These include exercises, Tai Chi, walks outside, gardening, games and quizzes.  Those residents who prefer to stay in their room have one on one visits to check if there is anything they need and to have a chat. The DT may take the residents books, puzzles or crosswords.  There are fortnightly church services and the nuns visit weekly to give communion.  The facility is fundraising to buy a minivan but at present, rents a van for outings. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers’ Day and Anzac Day are celebrated.  Residents have an activity assessment completed over the first few weeks following admission that describes the resident’s past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The four care plans reviewed had been evaluated by the registered nurses six-monthly or when changes to care occurs. Short-term care plans for short-term needs were evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activity plans are in place for each resident and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home residents and one-monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan. |
| 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 | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where two residents had been referred to the mental health team for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. |
| 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 policies regarding chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff. The maintenance person described the safe management of hazardous material. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness (3 May 2017). There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.  Electrical equipment has been tested and tagged. All three hoists have been checked and tagged. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges are carpeted. The hallways and utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents’ rooms are carpeted and ensuites, communal showers and toilets have nonslip vinyl flooring. All halls have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. The facility has their own orchard and produce from this is used in the kitchen. There are attractive outdoor areas with seating and shade. There is safe access to all communal areas. |
| 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 | There are 17 single rooms which share communal showers and toilets. There are two double rooms with ensuites and one treble room with ensuite. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are well maintained and easy to clean. There is ample space in all toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are privacy signs on all shower/toilet doors. |
| 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 | Residents' rooms are spacious and allow care to be provided and the safe use of mobility aids. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. The two additional rooms which has been converted since the last audit are spacious and can safely accommodate rest home and hospital level care. |
| 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 | Seating and space is arranged to allow both individual and group activities to occur in the two communal lounges. Both lounges open out onto attractive decking areas. There are areas where residents who prefer quieter activities or visitors may sit. There are two dining rooms which are more spacious and the décor is homely. |
| 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 | Laundry is contracted out. There is a laundry on-site but this is only used for ‘delicates’ and personals which the caregivers do. The laundry is divided into a ‘dirty’ and ‘clean’ area. There is a comprehensive laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaners’ equipment was attended at all times or locked away in the cleaners’ room as sighted on the day of the audit. Cleaning is done by two on-site cleaners. There is one sluice room for the disposal of soiled water or waste. The sluice room and the laundry are kept locked when not in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and mandatory education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.  There are adequate supplies available in the event of a civil defence emergency including food, water, blankets and a generator. A gas barbeque is available.  A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity.  There is a minimum of one staff available 24 hours a day, 7 days a week with a current first aid/CPR certificate. |
| 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 | The facility has ample natural light and ventilation. All heating is electrical. Staff stated that this is effective. The facility has a small outside smoking area for two residents who smoke. All other areas are smoke-free. |
| 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. | PA Low | Whangaroa Health Services has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical manager is the designated infection control coordinator with support from all staff members of the infection control team. Infection control is discussed at all staff meetings. Minutes are available for staff. Spot 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 not been reviewed annually. |
| 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 | A registered nurse is the designated infection control (IC) coordinator and has recently completed the Ministry of Health online infection control training. There are adequate resources to implement the infection control programme at Whangaroa Health Services. The infection control team is representative of the facility. External resources and support are available when required. 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. |
| 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 | Whangaroa Health Service’s infection control policies and procedures are appropriate 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 policies have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | 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. All infection control training has been documented and a record of attendance has been maintained. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. |
| 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 Whangaroa Health Service’s 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. There is no evidence that this information is being analysed or trended (link 1.2.3.6). Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the CEO and clinical services manager. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The facility has restraint philosophy aiming at being restraint free. There are restraint minimisation and safe practice policies and procedures in place. There is a restraint and enabler register. There is a designated restraint ‘champion’. When interviewed the clinical manager reiterated the facility’s no or minimal restraint philosophy. There are currently two hospital residents using a restraint. |
| 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 | There is a restraint policy and procedure for all staff to follow. Consent for restraint is obtained from the resident/EPOA, clinical manager and general practitioner (GP). Approved restraints are documented in the restraint register and in the care plan. Approval for restraints used are reviewed three-monthly. Alternatives to restraint are not documented (link 2.2.2.1). Staff attend restraint education annually. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | All residents have a thorough assessment before restraint is used. Staff investigate any underlying causes for relevant behaviours/condition. Any risks for use of the restraint are documented. All cultural practices are taken into account as well as any background knowledge of previous restraint use. The resident is informed about the use and duration of the restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The restraint ‘champion’ is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation with the consumer (as appropriate), family/whānau and the GP.  Restraint use is reviewed three-monthly. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring requirements are documented and the use of restraint evaluated regularly. There is a restraint register in place. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint champion. The use of restraints is discussed at the staff meetings. Evaluation timeframes are determined by policy and risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Monitoring of each episode of restraint occurs and this is well documented. Restraint use and review is discussed at staff meetings. |

# 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 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | The service has a complaints management policy that complies with the requirements of the Code. The service has complaint forms available throughout the facility. The CEO (interviewed) advised that complaints are documented in the complaints register. All complaints are investigated and where required, corrective actions are implemented. Not all complaints had been managed within the required timeframes. | Two of three complaints received were not responded to within the timeframes required by the Code. | Ensure that complaints management complies with the requirements of the Code and the organisational policy on complaints management.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The service has a documented quality improvement programme. This programme includes an annual audit schedule. Not all audits on the schedule have been completed. Quality improvement data is collected monthly across a number of areas, including (but not limited to): clinical indicators, health and safety, infection control, accidents and incidents and complaints. This information is collated monthly and the information is communicated to staff at staff meetings. The collated information is not consistently trended and analysed to identify opportunities for improvement. | i) Fourteen of forty internal audits scheduled have not been completed as per the audit schedule.  ii) Quality improvement data is not consistently trended and analysed to identify opportunities for improvement. | i) Ensure that the monitoring schedule is fully implemented.  ii) Ensure that all quality improvement data is trended and analysed and the results communicated to staff and residents where appropriate.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The service captures quality improvement data (clinical indicators, health and safety, infection control, accidents and incidents and complaints). The service participates in an external benchmarking initiative with four other facilities in Northland. The benchmarking group meet quarterly to discuss the collated data set.  Where the internal and external quality data is identifying opportunities for improvement at the service, corrective action plans are not consistently being documented. Where corrective action plans have been developed, these are not consistently evaluated and signed out. | i) Corrective action plans are not consistently documented where opportunities for improvements are identified.  ii) Not all corrective action plans are evaluated and signed off when completed. | i-ii) Ensure that corrective actions plans are documented where opportunities for improvement are noted and the corrective action plans are then implemented, reviewed and signed off once completed.  90 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 | As part of the quality management programme, an annual education plan has been documented. The education plan for 2016 was not fully implemented and the education plan for 2017 year to date has not yet been fully implemented. However, staff have been provided with eight hours of professional development annually which covers the training requirements of the Health and Disability Sector Standards. Staff have completed the required competencies in relation to manual handling, health and safety, infection control, medication management and food safety. One of six registered nurses have completed their interRAI training. The organisational policy requires all staff to have a performance review within three months of commencing work and then at least annually. Not all staff have completed the required performance reviews. | i)The education plan for 2016 and the education plan 2017 (year to date) have not been fully implemented.  ii) Three of six files sampled (cleaner, registered nurse and clinical manager) could not evidence that the required performance reviews had been completed. | i) Ensure the annual education plan is fully implemented.  ii) Ensure that all staff complete the required performance reviews.  90 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | In the medication files reviewed, the GP had prescribed all medication to be administered to the resident on admission. Not all ‘as required’ medications had been charted correctly. | i) Seven out of ten (two rest home and five hospital) medication charts reviewed did not have indications for use charted for ‘as required’ medication. | Ensure that all ‘as required’ medication prescribing meets all contractual and legislative requirements.  60 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. The evening meal is left by the cook to be reheated by the caregivers. Food temperatures are not checked. All other food management complies with current legislation and guidelines. | Reheated evening meals do not have food temperatures checked. | Ensure reheated evening meals have food temperatures checked.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | The RN reviews information gathered from assessments, monitoring charts, observations and interviews with residents, staff and families to develop the care plan. Not all interventions for assessed care needs were documented in sufficient detail to guide the care staff.  Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. Wound management/evaluation was not always signed off as completed.  The facility has a policy that if an unwitnessed fall occurs, neurological observations will be completed. This has not always occurred. | i) One respite resident in the rest home sample of two files had no details around care of the indwelling catheter and one resident in the hospital sample of three files had minimal de-escalation detail in the behaviour management plan.  ii) Wound care plans were not always signed off as completed.  iii) Neurological observations were not completed for two hospital residents following an unwitnessed fall. Neurological observations were commenced but not completed for the required timeframe for one hospital resident who had an unwitnessed fall. | i) Ensure interventions are documented in sufficient detail to guide the care needed.  ii) Ensure wound care plans are signed off as completed.  iii) Ensure neurological observations are completed according to policy.  90 days |
| Criterion 3.1.3  The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | The service has policies and procedures documented for infection control. The infection control coordinator has a signed job description. There is no evidence that the infection control programme has been reviewed. | The infection control programme has not been reviewed annually. | Ensure the infection control programme is reviewed annually.  90 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.