# Ngati Porou Hauora Charitable Trust Board - Te Whare Hauora o Ngati Porou

## 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 The DAA Group 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:** Ngati Porou Hauora Charitable Trust Board

**Premises audited:** Te Whare Hauora o Ngati Porou

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

**Dates of audit:** Start date: 23 August 2017 End date: 24 August 2017

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 8

# 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

Te Whare Hauora o Ngati Porou provides rest home and hospital level care, medical services and primary maternity services for 15 patients. The service is owned by Ngati Porou Hauora Charitable Trust Board. The hospital has a hospital services manager and the ward is managed by the registered nurses. Patients and whanau spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the services contract with the Tairawhiti District Health Board. The audit process included review of policies and procedures, review of patients` and staff records, observations and interviews with patients, whanau, the service manager, quality manager, staff and a medical officer.

The service has Baby Friendly Hospital Initiative Accreditation which expires October 2017.

At this audit three areas have been identified as requiring improvement in relation to medication competencies, hazardous substances identification and the fire drills not being undertaken to meet legislative requirements.

## Consumer rights

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

The Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to patients. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of patients and staff were noted to be interacting with patients in a respectful manner.

Patients who identify as Maori have their needs me in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Maori Health Plan and related policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained

Open communication between staff, patients and whanau is promoted and was confirmed to be effective. There is access to formal interpreting services if required.

The service has strong linkages with a range of specialist health care providers, which contributes to ensuring services provided to patients are of an appropriate standard.

Staff and patients interviewed were fully aware of the complaints process. Complaints are investigated and responded to in a timely manner.

## Organisational management

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| --- | --- | --- |
| 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. |  | Standards applicable to this service fully attained. |

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from patients and families/whanau. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of patients.

Patients’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant patients` records are maintained in using an integrated hard copy record.

## Continuum of service delivery

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

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the hospital is appropriate and efficiently managed for the patients` requiring long term residential care and respite care. When a vacancy occurs, sufficient and relevant information is provided to the potential patient/whanau to facilitate the admission.

Patients` needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility supported by care and allied health staff and a designated medical officer. The midwife manager is also available 24 hours a day, seven days a week for the primary maternity service provided. Women can be admitted at any time for an assessment and/or in labour. On call arrangements for support from registered nurses and the hospital services manager are in place. Shift handovers and communication sheets guide continuity of care.

Patients’ care plans are individualised, based on comprehensive and an integrated range of clinical information. Short term assessments and care plans are developed to manage any new problems that might arise. All patients` records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Patients and whanau interviewed reported being well informed and involved in care planning and evaluation, and that the care provided was satisfactory. Patients are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned weekly activity programme for the residential care patients is facilitated by the ward staff providing patients with individual or group activities and maintaining their links with the community as able. Parenting education is provided by staff at every opportunity in the maternity unit.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses in the case-mix ward and the midwife manager in the maternity service. Staff have been assessed as competent to do so.

The food service meets the nutritional needs of the patients with special needs catered for. A food safety plan is being developed and policies guide food service delivery, supported by staff who have completed food safety qualifications. The kitchen was organised, clean and met food safety standards. Patients verified satisfaction with meals.

## Safe and appropriate environment

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

The facility meets the needs of patients, was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste is well managed. Staff use protective equipment and clothing. Soiled linen and equipment are safely stored. Laundry is undertaken offsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and are aware of their responsibilities in a fire evacuation. Residents reported a timely staff response to call bells. Security is maintained.

## 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. |

Ngati Porou Hauora has implemented policies and procedures that support the minimisation of restraint. Three restraints were in use at the time of audit. No enablers were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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. |  | Standards applicable to this service fully attained. |

The infection prevention and control programme aims to prevent and manage infections. There are terms of reference for the infection control committee which meet quarterly. The programme is overseen by experienced registered nurses and a healthcare assistant. Specialist infection prevention and control advice can be sought from the microbiologist from the laboratory service utilised, or from the medical staff, general practitioners in the region and locum general practitioners who cover the services.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and procedures and supported with regular education.

The surveillance programme covers the case mix including medical, maternity and aged care services. All surveillance undertaken is collated, analysed and trended and results reported to staff and management. Follow-up action is taken as and when required.

## 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 | 48 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 100 | 0 | 2 | 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 | Ngati Porou Hauora Charitable Trust hasNgat developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers` Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| 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 | Nursing, midwifery and health care assistants interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical records reviewed show that informed consent has been gained appropriately using the organisation’s consent forms including for photographs, investigations and for any procedures or treatments required for individual patients.  Systems are in place to ensure wahine/women, and where appropriate, their whanau/family, are provided with information to make informed choices and informed decisions. The Lead Maternity Carer (LMC) midwife for Te Puia Hospital interviewed discussed with women in the antenatal booking period the options available throughout pregnancy, labour and delivery of the baby. Written consent is obtained, for example, for Anti D immunoglobulin administration, and verbal consent for the Guthrie test to be performed on the baby. Wahine/women are able to choose whether they retain their whenua/placenta after the birth, or alternatively, it can be disposed of as per protocol. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, patients are given a copy of the Code, which also includes information on the Nationwide Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available in the maternity unit and the ward. Whanau members and patients spoken to were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff are aware of how to access the Advocacy Service. The hospital LMC midwife manager confirmed understanding of how to access an advocate if needed regionally or through the New Zealand College of Midwives (NZCOM). |
| 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 | Patients receiving long term care are assisted to maximise their potential for self-help and to maintain links with their family and the community. For the acute medical and maternity patients, whanau are encouraged to visit any time and whanau are able to participate as able. In the maternity care setting the partners are able to stay at the facility for the duration of the time in the unit. The ward staff care for the wahine/woman and pepe/baby when the midwife is not present in the unit. Whanau interviewed stated they felt welcome when visiting and comfortable with their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | A complaints policy is in place and the documented procedure for making, receiving and resolving complaints enables complaints to be resolved simply, fairly and quickly. Policy states that complaints will be dealt with in a professional manner to meet Right 10 of the Code. There is an up to date electronic complaints register, which had five complaints documented in the last eight months. These complaints had been acknowledged within five days, responded to and closed. Complaints data is trended by service area and risk category.  Patients and whānau interviewed understood their right to complain and stated they know how to complain. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.  There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Patients/residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission process. A comprehensive information pack is provided to all wahine/women entering the maternity service. Ngati Porou Hauora Charitable Trust services are all provided using Te Puia Hospital. The Te Puia Hospital information booklet is provided to patients in all other services on admission. The medical staff, midwife, registered nurses and enrolled nurses provide time to discuss advocacy and how to make a complaint or provide feedback. The Code is displayed in all service areas in both English and Maori. Pamphlets are accessible in the maternity unit and the ward. ealth and Disability AdvocacyHealth and Disability Advocacy Service |
| 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 | Patients and families confirmed that they receive services in a manner that has regard for their privacy, dignity, sexuality, spirituality and choices are provided.  Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, ensuring resident information is held securely and privately and when exchanging verbal information). Each patient has their own room. The four long term care patients have been able to personalise their rooms with photos and personal items of their choice.  The long term residential care patients are encouraged to maintain independence by joining in activities and outings into the community as able with whanau. Each care plan included documentation related to the residents` abilities, and strategies to maximise independence.  Records reviewed confirmed patient`s and resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service`s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records. Family violence screening occurs for all women/wahine entering the service and through all stages of service delivery. The midwives are fully trained and this is a requirement of the Midwifery Council of New Zealand competencies every three years. |
| 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 | Staff support the eight patients in the service on the day of the audit, all of whom identify as Maori, to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau to Maori patients. There is a current Maori Health Plan which is developed with input from cultural advisers. Current access to resources includes the contact of local cultural advisors, and Ngati Porou Hauora Charitable Trust Board members who are able to provide support as required. Five patients and two whanau members interviewed reported that staff acknowledge and respected their individual cultural needs. There are no barriers for Maori entering the acute, maternity and long-term services provided at Te Puia Hospital. |
| 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 | Patients verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Patient`s personal preferences, required interventions and special needs were included in all care plans reviewed. Women had a choice of whether to keep their whenua/placenta after birth or have this disposed of. A patient satisfaction questionnaire includes evaluation of how well patients` cultural needs are met and this supported that individual needs are being met. Women accessing the maternity service are provided with a feedback form in the information pack. Women also have the right to feedback through the New Zealand College of Midwives if they are not pleased with their midwife or any aspects of care including being culturally sensitive and appropriate. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Patients and whanau members interviewed stated that patients were free from any discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to patients in this isolated area.  The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Courses are available online with the Ministry of Health (MoH) as sighted in the training records. Staff are provided with a Code of conduct in both the staff orientation workbook and their individual employment contract. Ongoing education is provided on an annual basis, which was confirmed in the staff training records available. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through ongoing education and evidence based policies, input from external specialist services and allied health professionals, for example the district nursing service, the community physiotherapist (who now has some contracted hours at the facility), general practitioners, locum general practitioners and other health professionals as required. The general practitioner (GP) interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own networks to support contemporary good practice. This was verified by the midwife interviewed who attended education at Tairawhiti DHB (TDHB) when able, due to the distance to travel. The maternity service now leads the way with all staff attending the ‘PROMPT’ courses to manage emergency situations more efficiently, rather than travelling to the TDHB for training purposes. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Patients and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in patients` records reviewed. There was also evidence of patient/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirement of the Code.  Interpreter services are able to be accessed via the National Interpreter Service when required. Staff knew how to do so, although reported this was rarely required due to staff in the organisation who speak te reo Maori fluently, and whanau assistance, as needed. As this is a predominantly Maori Health Service staff are able to participate as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The purpose, values, scope, direction and goals of the organisation are clearly identified and are documented within key documents, such as job descriptions, annual reports and on the organisation’s website. The long-term vision reflects Ngati Porou tikanga and seeks to support a stronger tomorrow and a stronger next generation - “kia tu pakari, kei tua ō kapenga”. The operational goals are aligned to the strategic goals and are reported on monthly by the Hospital Services Manager. The manager is responsible for the provision of services, holds relevant qualifications and has over fifteen years’ experience in the sector. The role has the required authority and accountability and reports to the Chief Executive. A sample of monthly reports to the board of directors showed adequate information to monitor performance is reported including financial performance, emerging risks and issues.  Both the Chief Executive and Hospital Services Manager confirmed knowledge of the sector, regulatory and reporting requirements and maintain currency through their professional and contractual relationships. Weekly meetings are held with Tairawhiti District Health Board managers.  The service holds contracts with Tairawhiti DHB for, rest home, hospital level care, medical conditions, and primary maternity services. Three elderly patients were receiving hospital level care services, one was receiving rest home level care and four patients were receiving medical services. No women were receiving maternity care onsite at the time of audit. The service works closely with local emergency services due to the remote location. |
| 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 | Policy states that in case of a nurse manager’s absence, timely arrangements are made to relocate the absentee’s duties to a suitable person or to a management team member of staff.  The hospital manager is responsible for the rostering and is on call 24 hours a day, seven days a week. Due to the remote location of the community, registered nurses and medical staff live onsite and expect to be called on if required to maintain patient safety. Staff reported that they are satisfied with the arrangements to provide safe cover for their patients and that the current arrangements work well. |
| 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 has a process in place for the documentation and management of risks, hazards, incidents and accidents. The risk management plan 2016 – 2019 was reviewed. There is a health and safety committee who oversee all areas as required. There are comprehensive hazard registers which cover all service areas, such as clinical, external, cleaning and kitchen.  Policy and procedure reflect updated practice to ensure current related health and safety requirements are met. Ngati Porou Hauora has adopted an outcomes approach to managing risk, incidents and complaints in an integrated framework for an improved quality service that is consumer/patient/resident focused. Responsibilities ensures risks are monitored and maintained across the organisation. Quality improvement data is collated, analysed and evaluated and corrective action plans developed and implemented. Any potential risk are communicated to staff, patients/residents/visitors as needed.  The document control system is managed electronically, which provides alerts when documents are due for review. All documents sighted were approved, current and available to staff.  Incident reporting, complaints management, infection prevention and control, hazard management and restraint minimisation are incorporated into the quality and risk management system as required. Trends analysis has been performed as an evaluation of the quality and risk management plan for July to December 2016 against the organisation’s strategic goals.  Annual health and safety worksite inspections are done as per the policy requirements and corrective actions taken when required.  Key aspects of the quality and risk system are incorporated into the agendas of meetings at every level of the organisation.  Risks are severity rated and reported against by managers up to the chief executive and on to the Board depending on the severity. |
| 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 process for reporting and follow up of any adverse events is described in the Health and Safety Manual. This is well documented in policy and implemented across all services. A corrective action process is followed when the need for quality improvement is identified. The policy states statutory obligations in relation to essential notification reporting. Staff interviewed were aware of their responsibilities to each other and their patients/residents should an untoward event occur. Whānau indicated their satisfaction that they would be informed should there be an adverse event and review of the incident register indicated this. A recent notification earlier this year to the Ministry of Health and Tairawhiti District Health Board was sighted as an example of the organisation’s understanding of the need to report specific adverse events. |
| 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 | Employment processes reflect good faith employment principles with the provision of; job descriptions, interview processes, referee and police checking, and indication of a fair recruitment process. The most recent staff member employed was satisfied with the rigour of the process.  Human resources information identifies that new staff have a three-month post-employment review and annual appraisals thereafter. Nurses are appraised using the New Zealand Nursing Council appraisal template. A midwife is employed to manage the maternity service and is supported by a contracted community Lead Maternity Carer. The general practitioners are contracted and live onsite in the residences provided. Locum medical staff are contracted to cover leave. Relevant recruiting processes are used for contracted staff.  Staff orientation/induction processes are clearly set out. Prior to working on the floor, staff undertake introductory training, and attendance and their understanding was recorded on the orientation checklists sighted. Staff receive a full orientation which includes expected competencies covering; the Code of Health and Disability Consumers’ Rights, the organisation’s philosophy, policies and procedures manuals, confidentiality, infection control, restraint, complaints management, occupational safety, cultural awareness and advocacy. Emergency procedures, such as fire safety and evacuation, are also covered. RNs have an additional orientation which includes medication management. Staff interviewed expressed their satisfaction with the orientation they received.  Professional qualifications are validated annually and the manager has a reminder system to ensure each health care professional’s annual practising certificate is updated when due.  The recent development of an innovative training plan for all staff by group, which combats the challenges of geographical remoteness and lack of resource, is acknowledged as a specific highlight for the organisation. Continuous improvement will be evident following an evaluation of this comprehensive resource against patient safety outcomes, in the future. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The accepted best practice nurse to patient ratio is followed for rostering. The facility adjusts staffing levels to meet the changing needs of patients and residents. 24 hour/seven days a week cover is provided by a RN on duty in the hospital. The maternity service is run by a midwife employed full time and she is supported by a contracted LMC midwife who provides cover and peer review. An after-hours service is in place, with staff reporting that good access to assistance and advice is available when needed. Out of hours both a midwife and a general practitioner is on call. The general practitioner resides on the premises to enable timely responses in an emergency.  Staff reported there were adequate staff available to complete the work allocated to them. Patients, residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence.  Maternity services including delivery are provided in the hospital. General practitioners run emergency clinics from the hospital. Hospital nursing staff, general practitioners and the midwives have undertaken Primary Response in Medical Emergency (PRIME) training and the nursing staff who live onsite are available as required in an emergency. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | In the ward the patient`s name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all patients` information sighted. All necessary demographic, personal, clinical and health information was fully completed in the patient`s records sampled for review. Clinical records were current and integrated with the medical staff, and allied health service provider records. Records were legible with the name and designation of the person making the entry identifiable.  The maternity service records reviewed evidenced mother and baby records being maintained separately. No personal information is displayed in public view in the hospital or the maternity unit. The records for mother and baby are stored in a locked filing cabinet in a locked office. Copies of the mother and baby records are documented until the baby is six weeks post birth. The baby NHI number is obtained after the birth and is recorded on all records reviewed. All details of all patients are recorded in the hospital admission register.  Archived records are held securely on site both in the maternity unit and in the hospital main office and are readily retrievable as required. Patients` records are held for the required period before being destroyed. |
| 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 | Patients enter the service as acute admissions, wahine/women in labour or for an assessment, and for long term residential care. Acute admissions are admitted through the accident and emergency triage service and wahine/women in labour are admitted to this primary maternity service for care in labour, birth and postnatal care. In addition to this, wahine/women and their pepe/baby can be transferred to Te Puia Hospital from secondary care for postnatal care and management.  Patients admitted for long term residential care at rest home and hospital level have to be assessed prior to admission by the local Needs Assessment and Service Coordination (NASC) Service. Patients can be accepted for respite care through the NASC service or via the general practitioner. Information is provided about the service and the admission process in the Te Puia Hospital information booklet sighted. There is a more comprehensive information pack available for the maternity service that was available for review.  Whanau members and patients interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. The long-term care patients` records reviewed contained completed demographic details, assessments including the interRAI assessments, and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service arranges the transfer by phone to facilitate the transfer of any patients to and from acute care services. There is open communication between all services, the patient and the whanau. At the time of transition between services, appropriate information, including medication records is provided for the ongoing management of the patient. All referrals are documented in the progress records.  For the inpatient service, there is a self-discharge form and process to follow should a patient wish to self-discharge.This is also recorded in the hospital register of admissions/discharges/transfers.  Wahine/women transferred from the maternity service are stabilised prior to transfer. In an emergency transfer, the TDHB determines the mode of transportation required and available at the time. If the TDHB retrieval team is required, the TDHB organises the transfer totally. This is applicable for the acute service, inpatient and maternity services provided. The ‘SBAR’ communication assessment form/tool is used for all transfers. The whanau of the patient are kept informed during the transfer of their relative. |
| 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 Moderate | The medicine management policy is current and identifies all aspects of medicine management. A safe system for medicine management was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of the role and responsibilities related to each stage of medicine management. Staff training records were reviewed and staff who administered medicines had not completed medication competencies.  The eight day national medication record is utilised for the medical and maternity patients and the 16 day national medication record for the residential care patients in the ward. There are no standing orders as a doctor is available on a daily basis. A signature list was reviewed for all staff on this case mix ward, the general practitioners and locum doctors available to the service on a regular basis.  Medications are supplied to the facility from a contracted pharmacy. These medications are checked by a registered nurse against the prescription when delivered to the facility. Reconciliation occurs by the doctor and pharmacist.  The records of temperatures for the medicine fridge were reviewed and were within the recommended range.  All emergency drugs are checked regularly by the registered nurses inclusive of the emergency room.  All medication is stored in a locked cupboard in a locked room. Medication and all entries are checked regularly by the registered nurses. A medication trolley was sighted and this is locked when not in use.  Good prescribing practices noted include the prescriber`s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. For the residential care patients, there is evidence of the doctor reviewing the medication three monthly and this was recorded on the individual medication chart.  There were no patients self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in safe manner, should it be required.  Medication errors are reported to the registered nurse and an incident form is completed and given to the hospital manager. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified. |
| 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 food service is provided on site at the hospital by the team leader. The team leader works 32 hours a week and a relief cook is available for the remaining time and for relief as required. The team leader works seven days on and two days off. The relief cook also does additional hours such as 7.30am to 9.30am and 4pm to 6pm daily and assists if additional catering is required for functions or special events. The team leader works in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years.  The team leader is responsible for all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal. Legislative requirements are met. The service is currently preparing to meet the requirements of the food safety plan with the hospital administrator. Special diets are catered for and modified textures to meet the needs of the patients. The registered nurses complete a nutritional assessment for each patient on admission to the facility and a dietary profile is developed and given to the team leader. Patients` needs are documented on the white board in the kitchen for easy reference on a daily basis. Special diets are noted.  The staff working in this kitchen have all completed food hygiene and safety requirements. Temperature checks are maintained for all foods delivered and prepared for patients. Cleaning schedules are adhered to and the kitchen is clean and tidy.  Wahine or patients in the ward have choices at mealtimes and additional food is available if needed as required. The doctor`s meals are also catered for when working at the hospital and when on call.  Evidence of patient satisfaction with meals was verified by patient and whanau interviews, satisfaction surveys and patient meeting minutes. Patients were seen to be given sufficient time to eat their meal in an unhurried manner and those requiring assistance had this provided. |
| 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 | If a referral is received for a prospective long-term care patient and the prospective patient does not meet the entry criteria, the local NASC is advised to ensure the patient and the whanau are supported to find an appropriate alternative. If the needs of a patient change and/or they are no longer suitable for the service offered, a referral for reassessment to the NASC is made and a new placement found in consultation with the patient and whanau/family. Examples would be if a patient required secure dementia care. There is a clause in the access agreement related to when a patient`s placement can be terminated.  In the event of an acute admission not being admitted to this primary care service, arrangements would be made to transfer the patient to the appropriate service, such as for secondary or tertiary level care and management.  The midwife manager interviewed stated that wahine/women have to meet the criteria for entry to this primary birthing service. The midwife manager and the one LMC in the community are responsible for reviewing their wahine/women on an individual basis to decide acceptability. Wahine/women who arrived at the unit without a LMC or are un-booked, are screened and the hospital midwife is allocated and/or alternatively, depending on the risks involved, the woman would be transferred to Tairawhiti DHB Gisborne Hospital. A register of all wahine/women accessing the facility is maintained by the midwife manager. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing and midwifery tools. Assessment tools such as the Abbey pain scale, falls risk, Waterlow risk assessment, skin integrity, nutritional screening and depression scale, and mini mental health status are utilised, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of patient related information. All residential care patients have current interRAI assessments completed by one of five registered nurses. The manager of Te Puia Hospital and allied services is currently completing the management interRAI training. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of patients, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans in all services provided evidence of service integration with progress records, activities records (for long term care (LTC) patients), and medical and allied health notations clearly written, informative and relevant. Any changes in care required is documented and verbally passed on to relevant staff. Patients and whanau reported participation in the development and ongoing evaluation of care plans. In maternity, the progress records are updated with each contact with the mother and/or pepe/baby and the care plans are updated. Any information is handed over to the ward staff when the midwife is not present in the unit. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to patients was consistent with their needs, goals and plan of care. The attention to a diverse range of patient`s individual needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is provided that is satisfactory. Nursing staff and care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the patients` individual needs. |
| 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 activities for the long term care patients is provided by the ward staff. A social assessment and history is undertaken on admission to ascertain patients` needs, interests, abilities and social requirements. The activities programme is regularly reviewed and displayed by staff to ensure activities provided are meaningful to the patients. These activity needs are reviewed when the nursing care plan and re-assessment interRAI is completed.  Activities currently reflect the interests, skills, likes and dislikes of the four residential care patients in the ward. Other patients in the ward are able to join in if they wish. The staff interviewed enjoyed this aspect of their work and regular events are offered. Van outings are provided infrequently due to the patients not being able to participate so easily. One patient goes home with whanau as able and the physiotherapist is working with the whanau with regards to the transfer to car and back to wheelchair.  In maternity, activities are not organised as such, but all support is provided during the time the wahine/women and their babies are in the unit. Parenting education is a major activity and staff take every opportunity to promote educational activities such as safe sleep, screening procedures, settling babies, baby bathing demonstrations, positioning techniques for successful breastfeeding. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Patient care is evaluated on each shift and reported in the progress records. If any change is noted, it is reported to the registered nurse or registered midwife.  For the long term care patients, care evaluations occur six monthly in conjunction with the six monthly re-assessment interRAI or as a patient’s needs change. Evaluations are documented by the registered nurse. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being used and consistently reviewed were sighted for patients. Progress was evaluated as clinically indicated and according to the degree of risk noted during the assessment process. This was applicable for all patients irrespective of the services being provided. Patients and whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| 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 | Patients are supported to access or seek referral to other health and/or disability service providers. The medical practitioner on duty each day is responsible for all the patients in the hospital. If the need for another non-urgent service is indicated or requested, the doctor or rural health nurse sends a referral to seek specialist input. Copies of referrals were sighted in patients` records reviewed. The referrals are followed up on a regular basis by the doctor, the registered nurse or the rural nurse if a patient is discharged from the medical services. The patient and the whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending a patient to Tairawhiti DHB if needed.  The specialist obstetricians visit the service as required to review any patients referred for secondary care. This is significant for maternity to ensure wahine are assessed for the appropriate level of maternity care required and wahine do not have to travel the long distance to Tairawhiti DHB maternity services. |
| 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. | PA Low | Staff follow documented processes for the management of waste and infectious and hazardous substances. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew where to access this information.  There is a secured dangerous goods store available for use onsite and maintenance staff hold dangerous goods licences for transporting hazardous goods.  There is provision and availability of protective clothing and equipment and staff were observed using this.  Some signage is displayed where necessary as appropriate, however not all required signage is being used and there is no designated chemical handler who has completed the required Chemical Handling Approved Handler Training (HSNO).  The requirements for safe oxygen storage and handling was not well understood 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. | FA | A current building warrant of fitness (expiry date June 2018) is publicly displayed.  Appropriate systems are in place to ensure the patients’ physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that patients are safe and independence is promoted.  External areas are safely maintained and are appropriate to the patient groups and setting.  Staff confirmed they know the processes they should follow if any repairs or maintenance is required, and that any requests are appropriately actioned. Patients and whanau reported that they are happy with the environment, given the challenges of the age of the building.  The Maternity services unit is connected to the main hospital building and has an accessible separate entrance. Food and housekeeping services are provided by hospital staff and there is easy access to staff kitchen facilities for the midwives. Mothers and babies are housed in clean, restful surroundings conducive to the establishment of breast feeding. No mothers were present during the audit. The delivery suite is fit for purpose including emergency call bells to summon aid from the hospital if required.  Mothers interviewed expressed their satisfaction with the services provided. |
| 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 adequate numbers of accessible bathroom and toilet facilities throughout the facility. All patient bathroom and toilets are shared facilities, close to patient rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote patient independence. Locks on the facilities’ doors provide appropriate privacy for patients. |
| 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 | Adequate personal space is provided to allow patients and staff to move around within their bedrooms safely. Bedrooms provide a combination of single and shared accommodation. No rooms were being shared at the time of audit. Long term patients’ rooms are personalised with, photos and other personal items displayed.  There is room to store mobility aids, including wheel chairs. Staff and patients reported the adequacy of bedrooms. |
| 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 | Communal areas are available for patients and their whānau to engage in activities. The dining and lounge areas are spacious and enable easy access for patients and staff. Patients can access areas for privacy, if required. Furniture is appropriate to the setting and patients’ needs. |
| 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 | There are policies and procedures which guide staff in the cleaning and laundry processes. These are linked to the infection control programme and covers outbreak management.  Hospital laundry is undertaken off site by a contracted provider. Residents personal clothing is laundered by whānau or onsite in a dedicated laundry by nursing staff. Cleaning and ward staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Patients and whānau interviewed reported the laundry is managed well and their clothes are returned in a timely manner.  There is a small designated cleaning team who have received appropriate training. These staff have successfully completed the Ministry of Health online Infection Prevention and Control certificate, as confirmed in interview of cleaning staff and training records. Cleaning chemicals were stored in a lockable cupboard and were in appropriately labelled containers.  Cleaning and laundry processes are monitored through the internal audit programme and regular visual checks by the manager. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | The Ngati Porou Hauora Health Emergency and Business Continuity Plan is comprehensive, outlining the purpose of the plan with clear definitions of a health emergency and other emergencies. The plan covers the strategic components, operational components and administrative arrangements in the event of an emergency.  Staff have received training in fire safety and emergency procedures and have had recent experience earlier this year successfully implementing the plan, in response to a prolonged power outage.  The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ’s were sighted and meet the requirements for the organisation. Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested.  Call bells alert staff to patients requiring assistance. Call system audits are completed on a regular basis and patients and whānau reported staff respond promptly to call bells.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the RN on duty checks the premises at night. Police are called for any security emergencies. Staff reported they feel safe.  The last trial evacuation was over a year ago due to the stated difficulties of accessing Fire Service assistance with this. Staff are however aware of their responsibilities in an emergency evacuation situation and can describe the requirements of the current approved evacuation plan. |
| 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 patients’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto the outside ramp to the garden. Heating is provided in bedrooms and in the communal areas. Areas were warm and well ventilated throughout the audit and patients and whānau confirmed the facilities are maintained at a comfortable temperature |
| 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 | The service provides a managed environment that minimises the risk of infection to patients, staff and visors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a current infection control manual, developed at organisational level with input from the medical staff. The infection control programme and manual are reviewed annually. The programme is adequate for the size and nature of the services provided for this rural hospital.  There is a healthcare assistant and senior registered nurse who job share the infection coordinator position. The role and responsibilities are defined in job description. All infection control matters, including surveillance results, are reported monthly to the hospital manager and the quality manager. The committee is supported by a representative from food services and household management and the quality manager.  Signage is used as required. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| 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 healthcare assistant and the senior registered nurse who share the infection control coordinator role have undertaken infection control education as verified in the training records. The medical staff and general practitioners/locums support the infection control programme. Expert advice can also be sought from the community laboratory if additional support is needed. The registered nurses have access to the patient records and diagnostic results to ensure timely treatment and resolution of any infections.  The service has an outbreak kit but there have been no outbreaks since the previous audit. |
| 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 | The infection prevention and control policies reflect the requirements of the infection prevention standard and current accepted good practice. Policies were current and include appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good handwashing technique and use of personal protective resources such as gloves and aprons, as appropriate to the setting. Hand washing signage and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff education is outlined in the infection control programme. Interviews, observations and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. The registered nurses and enrolled nurses provided ongoing education and have completed the on-line MoH infection control training. The healthcare assistant also teaches hand hygiene to staff as part of the infection coordinator role. A record of attendance is maintained.  Education for patients is generally on a one-on-one basis and has included reminders about hand washing and about remaining in their room if they are unwell (one patient is currently in isolation) and signage was used and resources were readily available for staff/whanau to use. |
| 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 | Surveillance is appropriate for the size and nature of this case-mix setting. All reported infections are collated and analysed monthly to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via the staff meetings and at staff handovers. Benchmarking does not occur.  Any new infections and any required management plan are discussed at staff handover, to ensure early intervention occurs. Surveillance results are provided to the quality manager. The long-term care infection rate records are combined as one for reporting purposes. |
| Standard 3.6: Antimicrobial usage  Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians. | FA | Documentation, observations and interviews verified the provision of care provided to patients was consistent with meeting their needs, goals and the plan of care. The attention to meeting a diverse range of patient`s individualised needs was evident in all areas of service provision. The Doctor and clinical midwife manager interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is managed accordingly. Nursing, midwifery and care staff confirmed that care was provided as outlined in documentation. A range of equipment and resources are available, suited to the level of care provided and in accordance with the patients` needs. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint group provides support and oversight for enabler and restraint management in the facility. Staff demonstrated a sound understanding of the organisation’s policies, procedures and practice and her/his role and responsibilities.  On the day of audit, three patients were using restraints at night. No residents were using enablers. A similar process is followed for the use of enablers as is used for restraints, when enablers are used.  Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. |
| 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 restraint approval group, made up of the manager, quality co-ordinator and general practitioner, are responsible for the approval of the use of restraints and the restraint process. The general practitioner signs off all restraint approvals. It was evident from review of restraint approval group meeting minutes, residents’ files and interviews with RNs that there are clear lines of accountability,that all restraints have been approved, and the overall use of restraints is being monitored and analysed.  The restraints in use currently are bed rails at night for three short term respite residents who are unable to provide consent themselves, and who require this support for their safety.  Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.  Policy clearly describes the management of challenging behaviour and with the objective to protect individual residents, other residents, staff and visitors without the use of restraint. There is a challenging behaviour monitoring and assessment form should this occur. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint group’s involvement, and input from the person’s whānau/EPOA. The RN interviewed described the documented process. Whānau confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the person’s safety and security. Completed assessments were sighted in the records of patients who were using a restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The use of restraints is actively minimised and the RN described how alternatives to restraints are discussed with staff and whānau.  When restraints are in use, frequent monitoring occurs to ensure the patient remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.  A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all persons currently using a restraint and sufficient information to provide an auditable record.  Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Review of patients’ files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Whānau interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.  The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meeting reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and whānau. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with staff confirmed that the use of restraint at night time only is done in conjunction and with the consent of whānau, for the three people currently having short term respite care in the hospital. |

# 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 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, disposal, storage and reconciliation of medicines by the pharmacist and the medical staff when patients are admitted to the hospital services provided. Policies, procedures and guidelines are available to guide staff. The training programme for 2016 - 2017 and training records were reviewed. Staff training in relation to medication competencies had not been undertaken by staff. | The medicine training records sighted did not evidence that staff responsible for medicine administration had completed medication competencies since the last audit. | Provide evidence of medication competencies being completed annually for all staff who are responsible for medicine administration.  60 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 Low | Staff follow documented processes for the management of waste and infectious and hazardous substances. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew where to access this information. Housekeeping trolleys had labelled substances and these were stored securely when not in use. Information regarding oxygen cylinders was available to staff from the distributor. Storage of some hazardous substances did not consider the inherent risks of the substance. The oxygen storage area signage did not provide risk mitigation information. Some hazardous substances were stored without regard to the risks of spillage and mixing of incompatible substances. | Not all hazardous substances are labelled to allow for easy identification and safe use in line with current hazardous substances regulations and territorial requirements. No staff member holds an approved handler certification. | Ensure a relevant staff member becomes a certified approved handler, then review and make the changes required by current hazardous substances regulations regarding safe and appropriate storage. Provide evidence of this.  90 days |
| Criterion 1.4.7.3  Where required by legislation there is an approved evacuation plan. | PA Low | The last trial evacuation was over a year ago due to the stated difficulties of accessing Fire Service assistance with this. Staff are however aware of their responsibilities in an emergency evacuation situation and described the requirements of the approved evacuation plan. | Trial evacuations have not been staged in the required times and alternatives to Fire Service supervision not identified or sought. | Provide evidence an evacuation drill has occurred.  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.