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

## Introduction

This report records the results of a Surveillance 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:** Waihi Hospital (2001) Limited

**Premises audited:** Waihi Hospital & Rest Home

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

**Dates of audit:** Start date: 27 June 2018 End date: 27 June 2018

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 35

# 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

Waihi Hospital and Rest Home is a privately owned and operated service that provides rest home, hospital (geriatric and medical) and maternity levels of care for up to 56 residents and clients. On the day of the audit there were 35 residents and one maternity patient. The residents, patients and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident, maternity patient and staff files, observations and interviews with residents, patients, family members, staff and management. Residents, patients and family interviewed were complimentary of the service they receive.

The six previous shortfalls identified at their last certification audit remain areas for improvement. These include training, maternity staffing roster, care plan interventions, evaluations, medication management and self-medicating documentation.

This surveillance audit identified further improvements required around notification of family following an adverse event, maintaining quality and risk management systems, interRAI assessments, integration and implementation of care, documentation and medication competencies and training.

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

Families and friends are able to visit residents at times that meet their needs. The accident/incident form reminds staff to contact families following an adverse event. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

A facility manager and clinical manager/RN are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews with the owner of the service. A quality and risk management programme is documented, but not embedded or fully implemented.

Human resources are documented around employment practice. An orientation programme is in place for new staff. An education and training plan is established and includes in-service education, online training and competency assessments.

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

## Continuum of service delivery

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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. |

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 input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior health care assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities coordinator implements the activity programme in the rest home to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links.

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

Maternity Services:

In consultation with their lead maternity carer (LMC), women plan their care for labour, birth and/or postnatal transfer to Waihi Maternity Annex. Postnatal care is provided by healthcare assistants (HCAs) with assistance as needed from registered nurses working at the aged care facility attached to the maternity annex. Postnatal care plans are required to be developed by the LMC, to guide the HCA in the support and guidance she offers women, their babies and their families. The LMC is responsible for the prescribing and charting of medication required for normal birth and the postnatal period. Breakfast and snacks are available in the on-site kitchen, with lunch and dinner provided by the hospital and delivered to the annex.

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

A current building warrant of fitness is in place. Reactive and preventative maintenance is carried out. Chemicals are stored securely, and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician.

## 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. |

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

## 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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. There is an infection control coordinator who is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is reported to management and staff. This information is not currently collated. There have been no outbreaks.

## 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 | 7 | 0 | 3 | 8 | 0 | 0 |
| **Criteria** | 0 | 27 | 0 | 6 | 11 | 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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms, and brochures are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with five residents (three rest home and two hospital) and relatives, confirmed their understanding of the complaints process. Seven staff interviewed (three health care assistants (HCAs), two RNs, one activities coordinator and one cook) were able to describe the process around reporting complaints.There is a complaint register in place. The facility manager signs off each complaint when it is closed. One complaint was documented for 2017 and seven were documented in the register for 2018 (year to date). All complaints were documented as resolved. All nine complaints were reviewed. They were managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are instructed to record family notification when entering an incident into the system. Adverse events reviewed failed to consistently indicate that family are kept informed. Three (hospital) family members interviewed reported that they are informed following a change of health status of their family member. Resident/family meetings provide a venue where issues can be addressed. There is an interpreter policy in place and contact details of interpreters were available. Language and communication needs are used if alternative information and communication methods are available and used where applicable. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Waihi Hospital and Rest Home provides maternity service across five in-patient beds and aged care services for up to 51 residents. This includes four primary care inpatient (PCIP) beds for hospital level patients admitted under the care of the GP for up to seven days. There were 13 hospital level residents and 22 rest home residents in the aged care facility. This included one resident under the carer support contract (respite), one resident (hospital) under the post-acute convalescent care contract, and one resident (rest home) under a mental health contract. The remaining residents were under the aged residential care contract. In the maternity ward there was one woman in delivery on the day of the audit. The service is privately owned. The owner visits once a week to meet with the facility manager and is available via phone anytime. There is a 2018 quality and business plan in place. The vision and values of the facility are documented and posted in a visible location to share with visitors and residents. Documented goals are regularly reviewed and updated by the owner and facility manager.The facility manager has been in her role since November 2017. She previously worked as the national manager for a home and community service. She is supported by a clinical manager/RN who has been in her role at this facility for the past 15 years.The facility manager is new to the aged care residential and maternity environment. She has attended four hours of professional development through the DHB (year to date) and plans to attend a minimum of four more hours by November 2018. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | The quality and business plan 2018/2019 covers the categories of administration, human resources, clinical services, education, health and safety, quality management and maintenance. Specific and achievable goals are listed for each category. Staff interviews identified understanding of the quality system.A quality and risk management system is established and was being implemented at the facility’s last full certification audit (January 2017). Since this time, the previous facility manager left the organisation, four RNs resigned, and the clinical manager was needed as a carer. The RN vacancies have now been replaced, but RNs are new to the organisation and to nursing in New Zealand, so this is taking a large percentage of the time of the clinical manager. The facility manager is also new (November 2017) and has not caught up with the paperwork that has lapsed when there was no facility manager to provide direction.Policies purchased from an external consultant are in place. Policies are scheduled for regular reviews as per the document control guidelines. These policies and procedures and associated implementation systems, adhere to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality and risk management programme is designed to monitor contractual and standards compliance and the quality of service delivery. There are guidelines and templates for reporting although some templates have not been implemented (e.g., meeting minutes templates). Quality and risk data has not been collated and analysed to assist in identifying service improvements. Staff meeting minutes do not reflect results being discussed with staff. Staff interviews (two registered nurses, three health care assistants, one activities coordinator and one cook) confirmed that they have been introduced to the quality and risk systems.Annual resident surveys were last completed, collated and analysed in 2016. The survey has not been repeated since this time. The facility manager stated that plans are in place to survey residents in 2018.An internal audit programme schedule has been developed but is not being followed as per the schedule. Corrective actions were documented in a register but ceased to be documented after January 2017.Health and safety policies are established, and a health and safety committee was being formulated at the time of the audit. The hazard register has recently been reviewed and updated. Staff incidents/accidents, and unplanned or untoward events are documented on accident/incident forms. Falls prevention strategies are in place including sensor mats, low beds and intentional rounding. |
| 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 | There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. They are signed off by the clinical manager when complete.A review of 15 accident/incident forms identified that forms included follow-up by a registered nurse. There was a lack of evidence on the forms to indicate that family are kept informed (link 1.1.9.1). Neurological observations are completed for any suspected injury to the head. The accident and incident process is not being linked to the quality and risk management system (link to findings for 1.2.3).The facility manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. No section 31 reports have been required since the last audit. |
| 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 Moderate | Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (four health care assistants (HCAs), one cleaner) included a recruitment process (interview process, reference checking, signed employment contracts/collective agreements, job descriptions and completed orientation programmes). A register of registered nursing staff and other health practitioner practising certificates is maintained.The orientation programme provides new staff with relevant information for safe work practice. There is an annual in-service education and training plan that is complimented by an online training programme. An attendance register is not regularly completed to verify staff attendance. Mandatory training sighted for infection control and medication training and associated competencies reflected low attendance rates (also link 1.3.12.3). This previous area identified for improvement remains.Performance appraisals were behind schedule in four of the five staff files reviewed.Four of six registered nurses have completed their interRAI training. InterRAI assessments were behind schedule and not always completed (link 1.3.3.3). There are implemented and annual competencies for registered nurses including (but not limited to) medication and syringe driver competencies but these are overdue (link 1.3.13.3). A minimum of one person is available 24/7 with a current CPR certificate. The activities coordinator also holds a current CPR certificate.Maternity: At the time of the audit, there were seven healthcare assistants (HCAs) employed to provide care to women and their babies while they stay at the maternity annex. One of the HCAs was interviewed. The HCAs have a clear and concise job description. Orientation is provided by a senior HCA and is thorough and comprehensive. Education is provided on breastfeeding, CPR, and emergency situations. A new member of staff receives 21 hours of breastfeeding education, and thereafter 2-4 hours a year of education. CPR education is every two years, and emergency skills update also every two years for one hour. The seven lead maternity carers (LMCs) have current practising certificates, and therefore access agreements to Waihi Maternity Hospital. Records related to education sessions specific to maternity were not available to determine RNs and HCA’s have completed. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The facility manager and clinical manager/RN are on-site Monday – Friday.The rest home wing (occupancy 22 residents) is staffed with two HCAs on the AM shift (one 0700 – 1500 and one 0700 – 1300); two HCAs are on the PM shift (one 1500 – 2300 and one 1500 – 2000). The hospital wing (occupancy 13 residents) is staffed with one RN 24-hours a day, seven days a week. Three HCAs cover the AM shift (one 0700 – 1500, one 0800 – 1500 and one 0700 - 1330). Two HCAs cover the PM shift (one 1500 – 2300 and one 1500 – 1900).One RN and one HCA are rostered for night shift duties. The clinical manager assisted with night shift duties during the period of time where four RNs resigned with the comment that due to the high cost of agency staff, every effort is made to reduce their usage.An activities coordinator is rostered three days a week (link to finding 1.3.7.1). There are separate cleaning and laundry staff seven days a week.The PM shift RN was interviewed. The clinical manager and RN stated that there are times when PM staffing levels are not adequate but that they have the authority to increase the hours of the short shift staff if necessary.Residents and family interviewed reported there are sufficient staff numbers.Maternity: Staffing levels include seven LMC midwives contracted to provide on-call midwifery care for the facility with cover 24/7. There is a contact list provided with the LMC phone numbers for emergency situations. Each client has their own LMC identified (and back-up) who visits daily and is accessible by telephone. HCAs provide the on-site daily postnatal care for eight-hour shifts. The RNs in the hospital/rest home are able to answer the maternity emergency bell and provide assistance as needed (link 1.2.7.5). The current LMC roster did not have a named midwife for a 24-hour rostered period but does provide a list of on-call LMCs that can be called. This roster does not have a named LMC nominated per 24-hour period. Since the previous audit, there has been ongoing discussions and negotiations with the local district health board (DHB), Ministry of Health (MoH) and New Zealand College of Midwives (NZCOM) for this contract requirement and provision of care. A review of policy and processes identifies that the service is managing the risk. Advised that the service is being managed appropriately and staffing arrangements have been agreed to by the DHB, however there was no correspondence available to evidence this... |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | Aged Care. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Maternity service: Waihi maternity has an organised client file documentation system that is maternity focused. The entries are integrated with the LMC entries. Not all records included the name and designation of the writer. |
| 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 | Aged Care: There are policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. Competency had been signed by the GP and the GP and resident had given consent. The medications were stored in a locked drawer. There are standing orders in use and these meet the prescribing requirements. The facility uses a paper-based and blister-pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer medications in the hospital and senior HCAs in the rest home. Medication competencies and medication education is not always being completed annually. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked weekly. Eye-drops are not being dated once opened. Staff sign for the administration of medications. Ten medication charts were reviewed (including one carer support, one PACC and one mental health). Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. ‘As required’ medications had indications for use charted.Maternity. Medication charts are completed by the LMC’s and all clients self-administer medications postnatally. The medications required for obstetric emergencies are kept in a fridge in a locked room. The ordering of these medications is the responsibility of the LMCs who use the facility. The HCA does check expiry dates on medications and IV fluids. A selection of files also showed missing documentation in regard to prescribing, dispensing and signing off the medications. Medication storage facilities were not adequate. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | Aged Care: The service has two first cooks two second cooks and two fourth cooks who cover all shifts between them. All have current food safety certificates. The head 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 from bain maries in the rest home and hospital and on trollies with covers to keep the food warm in the maternity annexe. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. The kitchen staff stated that kitchen fridge and freezer temperatures and food temperatures were monitored and recorded, but no documented temperatures were sighted. However, their food control plan had been approved on 18 June 2018. The cook on duty stated that no temperatures had been checked the day of audit. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Changes to residents’ dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by a dietitian. Residents and family members interviewed were satisfied with the meals. Maternity: Breakfast is self-service from a kitchen within the maternity annex. There are cereals, bread and spreads, fruit and yoghurt available. If the women would like porridge, this can be brought over from the hospital kitchen.Lunch and dinner are provided from the hospital kitchen. One client who is vegetarian, stated that the kitchen initially struggled to provide her with a vegetarian meal, as there were no residents requiring this diet. But after a discussion with kitchen staff, vegetarian meals were prepared for her. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Aged Care: Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident-centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow. A previous finding in this area has now been met.Maternity: Waihi Maternity Annex provides labour and birth care for women who are booked to use this facility. Women can also transfer from a tertiary unit for their postnatal care. The HCAs and registered nurses from the aged care facility offer care and support postnatally for these women and their babies. On reviewing five sets of clinical notes, it was found that minimal documentation was written in care plans completed by the LMCs. There was a form where a plan could be documented, but where this was completed, the instructions were very brief and generic. Of the five client records reviewed, four were at a tertiary facility and there was a copy of the Labour and birth summary from that facility in the notes. However, the one birth at Waihi had no delivery summary in the clinical notes. There was no daily update to the care plans only a short entry by the LMC to report her visit. This previous audit shortfall continues to require improvement |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Aged Care: When a resident’s condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative’s health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents’ needs changed. Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads.Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently six wounds being managed. The RN interviewed stated that they can refer wounds to the wound care specialist nurse if required. There are currently no pressure injuriesMonitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. Maternity: Advised that communication between the LMC and the HCA is paramount in providing the safest and appropriate care to each woman and baby. These conversations result in safe and timely interventions. The continuity model of care is services aim. Interviews with an experienced HCA and a LMC described meeting the needs and outcomes of the woman during her in-patient care. However, the lack of documentation in the woman’s clinical notes, which did not always include interventions, or progress notes related to informed consent in regard to care, education and both physical and emotional well-being (link 1.3.5.2 & 1.3.5.3). |
| Standard 1.3.7: Planned ActivitiesWhere 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. | PA Low | There is one activities coordinator who works three eight-hour days a week. She attends three-monthly workshops and in-house education. On the days she does not work, volunteers come in and she leaves materials out. On the day of audit, rest home residents were observed playing bowls and rummikub and answering quizzes.There is a weekly programme in large print on noticeboards in the rest home. The hospital does not have a programme. In the hospital, the activities coordinator leaves materials out for nursing staff and volunteers. Rest home residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents’ needs. These include exercises, games, quizzes, music and brain teasers. One wing in the rest home has a room set up with art and games and the residents potter in there whenever they wish.Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.Church groups visit twice weekly and Catholic church members come in to give communion. Rest home residents have weekly van outings and they often take a thermos and cakes and have a picnic. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers’ Day, Anzac Day and the Melbourne Cup are celebrated. They also have pizza nights with alcohol provided.The facility has one cat, and a pet therapy team visits monthly.There is community input from a local retirement village, one resident goes out to the RSA and one resident potters in the facility’s vegetable garden.Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the 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. Resident meetings are held as required. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Aged Care: The three long-term care plans reviewed (of permanent residents) had been evaluated by the registered nurses six monthly or when changes to care occurs. Short-term care plans for short-term needs are not always evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the long-term residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. The family member interviewed confirmed that they are informed of any changes to the care plan. A previous finding in this area has still not been met. Maternity: LMCs visit their client each day and write a daily evaluation in the notes. However, there was little written in relation to care plans and goals, such as breastfeeding progress or concerns, infant bathing, safe sleeping, cord care, consent for Metabolic Screening, discussion around Newborn Hearing Screen and any referrals such as Well Child/Plunket (link 1.3.5.2, 1.3.5.3 and 1.3.6.1). However, when speaking with one of the mothers, the care and support she received was very much appreciated and given with kindness and attentiveness. |
| 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 is in place (expiry 24 April 2019). Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been maintained with safe paving, outdoor shaded seating, lawn and gardens. HCAs interviewed, confirmed there was adequate equipment to carry out the care according to the resident needs as identified in the care plans.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collects information obtained through surveillance, but this information is not collated (link 1.2.3.6). Infection control data is discussed with the facility and clinical managers and at staff meetings.The systems that are in place are appropriate to the size and complexity of the facility.There have been no outbreaks.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. There were four (hospital level) residents using enablers (bedrails) and two (hospital level) residents using restraints during the audit. A file of a resident using an enabler was reviewed. The resident gave written consent for the use of bedrails. The enabler was linked to the resident’s care plan and was regularly reviewed. Online staff training is available to staff covering restraint minimisation and enablers (link 1.2.7.5). |

# 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 1.1.9.1Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | A total of eighteen incident/accident forms were reviewed for the month of May 2018. Staff failed to document that family were kept informed following an adverse event, although all three families interviewed confirmed that they are kept well informed. | Fifteen of eighteen incident/accident forms reviewed for May 2018 were missing evidence that family were kept informed. In three instances where family notification was documented, it was written in the resident progress notes and not on the accident/incident form. | Ensure that the accident/incident forms evidence families are kept informed.90 days |
| Criterion 1.2.3.5Key components of service delivery shall be explicitly linked to the quality management system. | PA Low | Due to staffing issues in 2017 and 2018 (year to date) the internal audit schedule was put on hold. Staffing has recently been improved with the hiring of four RNs and the clinical manager plans to resume work on completing internal audits. | The internal audit programme schedule to monitor key components of service delivery is not being completed. For 2018, nine internal audits were scheduled (year to date) but none have been completed. The internal audit schedule for 2017 indicated that internal audits ceased to take place after August 2017. Annual resident surveys were last completed, collated and analysed in 2016. The survey has not been repeated since this time. The facility manager stated that plans are in place to survey residents in 2018. | Ensure the internal auditing schedule is implemented to monitor service delivery.90 days |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | Quality data are documented for incidents, accidents, and infections but this data has not been collated and analysed. A meeting minutes template was established in 2016, but there was no evidence to suggest that it is being followed. Staff meetings for the rest home and hospital are scheduled separately. The meeting minutes for the rest home were last sighted for 5 February 2018. No 2018 hospital staff meetings or maternity staff meetings were available for sighting. The facility manager reported that they have taken place but have not been typed. The last clinical meeting minutes were sighted for 26 April 2018. | Meeting minutes were not all available. There is a lack of evidence to suggest that quality data is collated, analysed and discussed with staff.  | Ensure that quality data is collated, analysed and discussed with staff.90 days |
| Criterion 1.2.3.7A process to measure achievement against the quality and risk management plan is implemented. | PA Low | Due to staffing issues, aspects of the quality and risk management system is not measuring achievements or areas for improvements. | The quality risk management system for 2017 and 2018 is not measuring achievements or corrective actions required. | Ensure the documented quality and risk management programmes measure both achievements and areas for improvements.90 days |
| Criterion 1.2.3.8A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | A system is in place for identifying corrective actions and documenting service improvements although this process ceased to exist after January 2017. | The corrective action plan register has not been updated since January 2017. | Ensure a corrective action planning process is put back into place.90 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | An education and training programme is being implemented but there is a low number of attendees for mandatory training and attendance for online training was not being recorded to assess attendance rates. Performance appraisals are behind schedule. Not all staff have completed training related to maternity emergencies i.e.: post-partum haemorrhage, neonatal CPR | (i) Only three mandatory in-services have been provided in 2018 (YTD). Mandatory training around infection control indicated that only 6 of 27 staff had attended; (ii) Attendance for online education could not be assessed during the audit to determine attendance rates; (iii) The new RN’s in aged care (who provide oversite to maternity) and the two new HCA’s in maternity have not all completed maternity emergencies training i.e.: post-partum haemorrhage, neonatal CPR. (iv) Performance appraisals are behind schedule. | (i) Ensure staff attend mandatory training to meet requirements of the aged residential care contract. (ii) Ensure records of staff completing online education are maintained. (iii) Ensure the new RN’s in aged care (who provide oversite to maternity) and the two new HCA’s in maternity have completed maternity emergencies training i.e.: post-partum haemorrhage, neonatal CPR. (iv) Ensure staff have a current performance appraisal.30 days |
| Criterion 1.2.8.1There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | Maternity: There are seven midwives (LMCs), who provide care to women within the Waihi Maternity Hospital annex. They are contracted to provide a service to their clients 24 hours a day, seven days a week. However, having interviewed two of the LMC’s, they believe it is not possible to have a structured process to provide this care as there are times when a rostered midwife would not be able to attend either their client or an unexpected admission of an un-booked woman. Each LMC is committed to trying to attend as required, especially if the situation is in regard to their own client, and they have a good back-up system in place within their group. They explain how they speak to the HCA and the registered nurse, and advise them as to the safest and appropriate care for each situation. There is an ambulance/paramedic service for urgent transfers.  | Maternity: The current LMC roster did not have a named midwife for a 24-hour rostered period but does provide a list of on-call LMCs that can be called starting at the top of the list and working down until a LMC responds. If a HCA fails to get hold of a LMC they would then call 111, as stated in the ‘Waihi maternity annexe-24-hour midwifery cover’ policy statement. The service policy clearly describes the process for accessing on-call midwives. There has not been an instance in this time when they have had a problem contacting a midwife for non-emergency or emergency issues matters. This continues to be an ongoing area for improvement. There was no correspondence available at audit to evidence ongoing discussions and negotiations with the local district health board (DHB) that the current staffing process at Waihi meets requirements. The manager advised that she has requested the DHB to document that the 24-hour roster is not needed. Whilst verbally she has indicated to the manager that this is fine, it is not currently in writing. | Ensure the current on-call rostering meets the contract and is approved for Waihi maternity service. Or ensure that the current process is approved by the DHB in writing60 days |
| Criterion 1.2.9.9All records are legible and the name and designation of the service provider is identifiable. | PA Low | Maternity: Waihi maternity has an organised client file documentation system that is maternity focused. The entries are integrated with the LMC entries. On reviewing five sets of notes, it was evident that the documentation was signed, but no written name, designation, or sample signature provided. Drug charts also showed no name, designation or sample signature. | Maternity: On reviewing five sets of notes, it was evident that the documentation was signed, but no written name, designation, or sample signature provided. Drug charts also showed no name, designation or sample signature. | Ensure records include the writer’s name and designation and/or a copy of sample signatures are available for reference90 days |
| Criterion 1.3.12.1A 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 | Aged Care: Medications are prescribed by the GPs. RNs administer medications in the hospital and HCAs in the rest home. Eye-drops are not dated when opened. Pharmacy delivers the medications and checks them in with a RN. The standing orders are reviewed annually and meet the standing order regulations. The pharmacy completes six monthly checks of medications. All medications are stored safely. All medications that are no longer required are returned to pharmacy for disposal. Maternity: Ten client’s charts were assessed. Four of the medication charts reviewed were written correctly by the LMC. The remaining six had incomplete documentation in regard to prescribing, administering and signing of the medications. Allergies were not routinely documented. There is no specific place in the woman’s room where her medication can be stored safely. The drug cupboard in the maternity annex is locked and contains no controlled or restricted medications.  | Aged Care: Eye-drops are not being dated when opened.Maternity: (i)Six of 10 medication records had missing documentation in regard to prescribing, administering and signing of the medications. (ii) One medication chart had an allergy noted, the remaining charts had no documentation. One booking and admission form had an allergy noted, but this was not indicated on the medication chart. (iii) There is no specific place in the woman’s room where her medication can be stored safely. (iv) The LMC interviewed stated the existing medication chart is confusing to complete. | Aged Care: Ensure eye-drops are dated when opened.Maternity: (i) -(iii)Ensure all medications are prescribed correctly, including the noting of allergies, prescribers full signature, full name written clearly and designation. (iv) Ensure client rooms have a safe place to store medication while an in-patient. (v) Ensure the medication chart is easy to follow for the prescriber30 days |
| Criterion 1.3.12.3Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | There is a mandatory training programme that identifies medication training and medication competencies required annually. Not all staff administering medication have up to date competencies or have attended the mandatory training. | Aged Care/Maternity: Medication competency assessments are overdue for six of nine healthcare assistants (HCAs) and five of the six RNs. Mandatory medication training indicated that only 5 of 15 staff who administer medication attended.  | Ensure medication training and medication competencies are completed annually for applicable staff30 days |
| Criterion 1.3.12.5The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | Maternity: The LMC is responsible for prescribing and charting medications required for normal birth and postnatal care. All women self-administer their own medication. According to medicines management policies, each woman receives a medication chart, completed by her LMC, to record the taking of medications. A review of ten clinical files identified self-medicating charts were not being implemented as per policy. | Maternity: A review of ten clinical files identified self-medicating charts were not being implemented as per policy: (i)Three files had no medication chart at all, but in the clinical notes it has been documented that medication was taken by each woman, (ii) Four files had a self-medicating consent form to be signed by the woman, that were not signed.  | Maternity:(i)-(ii)Ensure every client has a self-medicating chart if requiring medication, and that all self-medicating charts are fully completed and reflect current legislation and guidelines.30 days |
| Criterion 1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Aged Care: A RN undertakes initial assessments such as pain, nutrition and pressure injury risk. They also undertake interRAI assessments, but these are not always completed within the required timeframes. When completed, the interRAI assessment linked to the long-term care plan. Interventions documented were relevant and guided care staff in the delivery of personalised care. Evaluations of long-term care plans are completed six monthly or as required (link 1.3.8.2). | Aged Care: Two of two ARC long-term residents (rest home and hospital) did not have interRAI assessments.  | Ensure interRAI assessments are completed for all long-term care residents.90 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Maternity: Five sets of clinical notes were reviewed. All five files had minimal interventions documented in the care plans by the LMCs to support all levels of care required for the mother and baby. Not every set of notes had a care plan. The care and support for women using this facility is, in the first instance, undertaken by the HCA.  | Maternity: (i)Five sets of clinical notes were reviewed. All five files had minimal interventions documented in the care plans by the LMCs to support all levels of care required for the mother and baby. There was a form where a plan could be documented, but where this was completed, and the instructions were very brief and generic. (ii) Not every set of notes had a care plan. (iii) One birth at Waihi had no delivery summary in the clinical notes. There was no daily update to the care plans reviewed only a short entry by the LMC to report her visit.  | Maternity: Ensure LMCs provide clear and concise care plans for each of their clients and her baby. Ensure a labour/birth and infant summary is kept in the client records; and ensure daily updates to the postnatal care plan are documented. 60 days |
| Criterion 1.3.5.3Service delivery plans demonstrate service integration. | PA Moderate | Maternity: Although the HCA interviewed was very experienced, it was evident from the clinical notes reviewed that the less experienced HCAs need clearer guidance and written documentation from the LMC. It is the LMCs responsibility to continuously assess her client’s needs, and update the HCA as to how to best achieve these needs. While the verbal communication between the LMCs and HCAs is in place, as per interviews, the written communication is lacking. Care plans reviewed did not include support needed around breastfeeding, education, referrals or discharge procedures. | Maternity: While the verbal communication between the LMCs and HCAs is in place (as per interviews); the written communication is lacking. Care plans did not include support needed around breastfeeding, education, referrals or discharge procedures. Clinical records (progress notes) did not always include informed consent discussions, daily discussions between mother, LMC and HCA and deviation from the care plan. LMC’s visited their client each day and write in the notes, but there was little written in relation to care plans and goals, such as breastfeeding progress or concerns, infant bathing, safe sleeping, cord care, consent for Metabolic Screening, discussion around Newborn Hearing Screen and any referrals such as Well Child/Plunket.  | Maternity: Ensure care plans include support needed around breastfeeding, education, referrals or discharge procedures. Ensure daily progress notes identify the care provided (including deviations from the care plan) and progress of the mother and baby. Ensure daily progress notes include discussions, evaluations, referrals and discharge planning.90 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Maternity: Communication between the LMC and the HCA is paramount in providing the safest and appropriate care to each woman and baby. However, there was a lack of documentation in the woman’s clinical notes, including breastfeeding records and discharge planning. | Maternity: The client interviewed stated she completed a breastfeeding record sheet. However, there was no evidence of this in the clinical notes, or any of the five clinical notes reviewed. There were no discharge plans for the mother and her baby documented. | Maternity: Ensure clinical records include breastfeeding records and discharge plans.60 days |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Aged Care: As the activities coordinator only works three eight-hour days and also covers taking residents to appointments, there are serious time constraints. There are very few planned activities in the hospital. The activities coordinator leaves out materials for the nursing staff and volunteers but if nursing staff are busy or there are no volunteers there are no activities. Rest home residents have weekly van outings. Hospital residents do not have van outings. | Aged Care: The activities coordinator only works three days a week. Although there are volunteers there are very few planned activities in the hospital due to time constraints. There is no documented hospital activities programme. Hospital residents do not have van outings. | Aged Care: Ensure more hours are allocated to hospital activities and that there is a documented hospital activities programme including van outings.60 days |
| Criterion 1.3.8.2Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Aged Care: Long-term care plans are evaluated six monthly or when changes to care occur. Short-term care plans are not always evaluated so do not show progress towards meeting goals. When a short-term issue is resolved, the short-term care plan is not always being signed off. | Aged Care: Four out of four short-term care plans reviewed did not document evaluation of progress towards the desired goal or had not been signed off when resolved. | Aged Care: Ensure short-term care plans are evaluated to monitor progress towards the desired goal and are signed off by a RN when resolved.30 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.