

Waihi Lifecare (2018) Limited - Waihi Hospital and Rest Home

Introduction

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

The audit has been conducted by 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](#).

The specifics of this audit included:

Legal entity:	Waihi Lifecare (2018) Limited
Premises audited:	Waihi Hospital and Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Hospital services - Maternity services
Dates of audit:	Start date: 23 August 2018 End date: 24 August 2018
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:	34

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.

General overview of the audit

Waihi Rest Home and Hospital provides rest home, hospital and maternity level care for up to 56 residents and clients. The facility is privately owned and managed by a facility manager. The facility manager is supported by a clinical manager. Residents and families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contracts with two district health boards. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents/clients, family members, management, staff, a general practitioner and the proposed new providers.

The audit has resulted in areas requiring improvement relating to interRAI assessments, medication management including storage, prescribing and medication records, food storage, service agreements, the activities programme, evaluation of care and equipment replacement.

The facility is being purchased by Waihi Lifecare 2018 Limited who currently own one other aged care facility. The purchase date has not been confirmed at the time of audit. The transition plan was discussed, and management are aware of the changeover. Staff, residents/clients and families have not yet been informed.

Consumer rights

Residents/clients and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents/clients and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents/clients and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's/client's needs.

The requirements of the Code are met including for complaints management.

Organisational management

The scope, direction, goals, values and mission statement of the organisation are known and followed. Monitoring of the services provided to the governing body was 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 residents/clients and families. 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 and the current number of residents. Maternity healthcare assistants are on call twenty four hours a day seven days a week to cover the maternity annexe.

Residents'/clients' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/client/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed on a regular and timely basis. Residents are referred or transferred to other health services as required.

The lead maternity care midwives are responsible for their clients and access clients on a daily basis when in the maternity annexe. Maternity healthcare assistants provide care and support to clients with breast feeding and baby cares. Parental education is provided at every opportunity.

There is an activity programme which provides and maintains links with the community.

Medicines are managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Residents verified satisfaction with meals.

Safe and appropriate environment

Waihi rest home and hospital meets the needs of residents/clients and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment and equipment requiring calibration has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shading and seating. The maternity annexe is appropriate for a primary birthing service and has a homely environment.

Waste and hazardous substances are well managed. Staff use personal protective equipment and resources as needed. Chemicals, soiled linen and equipment are safely stored. The laundry and cleaning is undertaken on site.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills.

Families, residents/clients reported a timely response to call bells. Security is maintained.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler and four restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular review is described in policy. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff interviewed demonstrated knowledge and understanding of the restraint and enabler processes. Education is provided to staff.

Infection prevention and control

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. 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	43	0	5	2	0	0
Criteria	0	93	0	6	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The service has 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. This included the maternity healthcare assistants who are employed to cover the maternity annexe. The lead maternity carer (LMC) interviewed was able to describe the responsibilities as an LMC in relation to the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning is discussed with the</p>

		<p>GP. Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented but does not always occur (see criterion 1.3.1.4). Staff were observed to gain consent for day to day care.</p> <p>The maternity hospital aid interviewed understood about the consent for the woman to retain the whenua/placenta or to have this disposed of after the birth.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, all residents and new mothers in the annexe (maternity unit) are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents/clients spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. There is information in the rest home, hospital wings and the maternity annexe identifying the local advocate based in the community and their contact details.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has a sign at the front door stating visiting hours are between 10 am and 8 pm. The clinical nurse manager interviewed stated that there are unrestricted visiting hours for family and close friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p> <p>In the maternity annexe visitors are welcome during the visiting hours. Partners are able to stay and provide support if they wish. A support person is discussed with the lead maternity carer midwife at about thirty six (36) weeks gestation. Clients interviewed confirm they have access to visitors of their choice. Clients are provided with a wide range of pamphlets which identify the support services available within the community.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation has a complaints policy with associated forms that meet the requirements of Right 10 of the Code. The facility manager interviewed stated information is provided to residents and family members on admission and there is a complaints information available at reception. This was confirmed by staff during interview. Family members spoken with knew of the complaints process and who they approach if they had a problem, this included the facility manager, the lead maternity carer, clinical manager or the registered nurse on duty.</p> <p>The complaints register reviewed showed that twenty-two (22) minor complaints have been received since January 2018. It included documentation of actions taken, through to an agreed solution. The register showed the required follow-up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow-up. All staff interviewed confirmed they have received related training and demonstrated a knowledge and understanding of the complaint process and what actions are required. Training was confirmed on review of staff training records.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in the main areas of the facility together with information on advocacy services, how to make a complaint and feedback forms.</p> <p>The LMC interviewed verified that opportunities for discussion about the Code with clients and information was provided at the first point of contact with the client. Information was sighted in the maternity annexe in poster and pamphlets which were readily accessible.</p> <p>New Provider Interview August 2018: The prospective provider is an experienced aged care sector provider they have a good understanding of the requirements of the Code as part of their existing roles.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents in the rest home and annexe (maternity wing) have a private room. In the hospital wing there are four single rooms and four rooms with four beds with curtains which separate the four areas. The clinical manager interviewed stated that at the time of admission consent is verbally discussed and obtained for the sharing of a room.</p> <p>Residents are encouraged to maintain their independence by attending community activities and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>All clients and their family/whanau have access to a service that promotes independence, involvement in decision making, respect and promotes confidence in caring for their new baby. The maternity healthcare assistant interviewed confirmed an understanding of the client's right to privacy. Support is provided in a manner that is responsive to client needs and promotes a healthy community. The lead maternity carers are actively working with the community to reduce the onset and consequence of family violence against women. The LMCs receive education through the New Zealand College of Midwives every three years.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability</p>	<p>FA</p>	<p>Staff support residents/clients in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of</p>

<p>needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>Waitangi are incorporated into day to day practice, as is the importance of whānau. The clinical manager interviewed reported that there were no residents who affiliated with their Maori culture at the time of audit. There are no barriers in supporting residents/clients who are admitted to the facility who identify as Māori. There is no specific current Māori health plan, however all values and beliefs are acknowledged and integrated into long-term care plans with input from cultural advisers within the local community as required. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</p> <p>The Waihi maternity annexe provides services which respect and acknowledge the needs of Maori and the cultural needs of birthing wahine. Providing culturally appropriate services is seen as supporting a healthy community. Ethnicity is documented on the booking form. Any identified cultural needs are documented in the midwifery notes if identified. Information about the Code is provided in Te Reo. The manager and staff demonstrates a commitment to whanau wellbeing by maintaining the organisations baby friendly hospital initiative status (BFHI) which expires in 2020 and ensures all staff receive adequate training.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. Interviews with residents and families confirmed that individual needs are being meet.</p> <p>Lead maternity carer midwives are required to indicate (at the booking stage) if an interpreter is required. Clients from ethnic origins are specifically asked to identify any special cultural requirements. The client and partner interviewed confirm they received services appropriate to their needs. Individual values and family/whanau beliefs were acknowledged and supported.</p>
<p>Standard 1.1.7: Discrimination</p>	<p>FA</p>	<p>Residents/clients and family members interviewed stated that</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>residents/clients were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. An LMC interviewed state that postnatal staff are aware of their professional boundaries and always work within their scope of practice. Performance appraisals sighted review feedback from peers and clients regarding the Code of conduct and boundaries. There are adequate processes in place to ensure discrimination does not occur. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included day to day discussions between residents and staff.</p> <p>The Baby Friendly Hospital Initiative policy and procedure manual includes the organisations breastfeeding policy, standards, principles of the Treaty of Waitangi, education, rooming-in, skin to skin, bed sharing, breast care, discharge, artificial feeding for mothers who feed their babies milk substitutes when medically indicated. Infant formula storage and recording and feeding with infant formula as medically indicated are clear for staff to follow and implement as needed. There was also a rooming in policy which clearly defined the reason and timeframes for removing baby from the mother's room. All staff and the maternity healthcare assistants have completed BFHI training. Training is in line</p>

		with the New Zealand Breastfeeding recommendations.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents 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 residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. There was one resident that was identified with a significant sensory impairment and resources and equipment were observed to be in place, for example, support from the Blind Foundation, talking books/radio and support from staff regrading mobility and daily activities of living.</p> <p>In this primary birthing maternity annexe clients' interviewed in person and on the phone reported they have sufficient time and support for discussions to occur. One on one support is provided by the maternity healthcare assistants. Discussions occur in private rooms. This service is achieving positive outcomes for clients and a range of local initiatives have improved breastfeeding outcomes for clients. Advocacy and support describe processes which support open communication.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>There is a quality plan that outlines the purpose, values, scope, direction and goals of the organisation. This is reviewed annually and is signed off by the facility manager. The document described the objectives of the service for 2018 to 2019. The facility manager reports to the owner director regularly by 'Skype' and by emailing. A sample of reports and minutes of meetings were reviewed. Information to monitor performance is reported including quality and risk, complaints and any health and safety issues.</p> <p>The facility manager has been employed in this role since November</p>

		<p>2017. The facility manager has a background in social work, has a Masters in Social Work. In addition to this, the facility manager was previously a home care support service coordinator with significant community services experience. Currently the facility manager is enrolled in a Bachelor of Human Resource Management and has completed the interRAI training for managers.</p> <p>The service holds contracts with two district health boards for rest home, hospital medical and geriatric and primary maternity service provision. The service has a total of 56 beds. Thirty-four residents were receiving services under these contracts. On the day of audit there were nineteen rest home and fifteen hospital residents. Five maternity beds are allocated with one client being admitted in labour and progressed to deliver the baby safely. In addition the service has agreements for four allocated GP beds and one bed was in use at audit, long term chronic (nil), respite care (one) and palliative care two (2) beds nil occupied.</p> <p>The prospective owners own another aged related care service and have a working knowledge of the contracts. The prospective owner has already been in consultation with the maternity services representative at the DHB in relation to the primary maternity contract and has a teleconference organised for next week. The prospective owners provided evidence of planning for transition and stated that the current staffing structure would remain unchanged. The two DHBs and the Ministry are aware of the plan to purchase this service. The first week of November is the proposed takeover but the actual date is not yet confirmed.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the facility manager is absent, the clinical manager carries out the required duties under delegated authority. During the absence of the clinical manager one of the registered nurses oversees the clinical aspects of the facility. They are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>The prospective owners stated they will continue with the present management structure and arrangements including contingencies when senior staff are not available.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a quality and risk system. The quality and risk plan 2018/2019 reflects the principles of quality improvement and was understood by staff interviewed. This includes the management of incidents and complaints, annual audit activities, an annual resident/family satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls and skin tears.</p> <p>The policies and procedures are reviewed two yearly. All policies and procedures are currently being reviewed by the facility manager and clinical manager and are due to be completed by December 2018. Dates are recorded on the footer of all policies and procedures of the date of review and the next review date. There is a document control system. Obsolete documents are filed, and archived records are stored in a secure place. Records can be retrieved if and when needed.</p> <p>There is a monthly quality and staff meeting which includes quality and risk and health and safety. The minutes of these meetings confirmed adequate reporting systems and discussion occurs on quality matters including pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results and activities. The health and safety committee established is new and the committee have recently held their first meeting. These separate meetings will be held three monthly. Minutes of the staff meetings showed that staff are informed of quality issues and this was confirmed by staff interviewed.</p> <p>The hazard register reviewed is linked to the quality and risk management system with actual and potential risk being identified. Staff interviewed in the rest home, hospital and maternity annexe understood what to do if they identified any hazards in any areas of service delivery.</p> <p>The prospective owners have a good understanding of quality and risk and the requirement to have a quality and risk plan for the service that promotes the principles of continuous improvement through an established internal quality programme, clinical indicators and current policies and procedures to meet the requirements of the standard and contractual obligations. Policies and procedures will be aligned with another facility owned by the prospective providers.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>FA</p>	<p>The facility manager and clinical manager interviewed were aware of their responsibilities to report to external agencies and were able to give examples of reporting to the Ministry of Health in relation to essential notifications. There have been no coronial enquiries or police investigations. There have been no legislative compliance issues that could affect the service.</p> <p>Staff documented adverse and near miss events on an accident/incident form. This was confirmed by staff during interview and included prompt reporting of any incident to the registered nurse, the clinical manager and/or to the lead maternity carer as applicable. The completed form is then followed through by the registered nurse in the first instance. For example, if a resident has a fall, a post fall assessment is completed, and vital observations are recorded by the staff. Monthly, the clinical manager identifies and categorises events by number and these are graphed electronically. The facility manager is currently working on the time of day to add into the electronic incident information for analysing if there are any trends identified. Hard copy forms are kept in a folder sighted and also entered electronically by the facility manager. A copy is retained in the resident's individual record. A sample of accident/incident forms showed these were fully completed, incidents were investigated, action-plans developed and actions were followed up in a timely manner. If relevant, incidents were discussed at meetings as examples of quality improvement.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures reviewed are in line with good employment practice and relevant legislation and guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes reference checks, police vetting and validation of qualifications and practising certificates (APCs) where required. The process was confirmed by the facility manager. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>The facility manager provided evidence of the orientation booklets</p>

		<p>provided to all staff to be completed at the commencement of employment. The booklets cover all necessary components relevant to legislation, the standards, contract requirements and good practice. Staff records showed documentation of completed orientation and performance reviews. The staff interviewed reported that they use a 'buddy' system as part of the orientation process and this worked effectively.</p> <p>The education plan for 2018 was reviewed. Compulsory mandatory training was provided and included fire emergencies and annual training on the Code of Rights, health and safety, restraint, manual handling, infection prevention and control, cultural safety, documentation, first aid, pressure injury prevention and medication management. Additional training includes end of life care, pain management, the aging process and continence management. The healthcare assistants have either completed or are enrolled in a New Zealand Qualification Authority Education (NZQA) programme to meet the needs of the provider's agreement with the DHB. The clinical manager is awaiting approval to be the site internal assessor for the Careerforce NZQA programme. Education records and staff records verified completion of the required training. Staff interviewed confirmed continuing requirements to attend training. Currently there are four registered nurses who are interRAI competent.</p> <p>The access agreement midwives are responsible for completing the mandatory training for their annual practicing certificates (APCs) and to maintain their individual access agreements. Annual and baby resuscitation is a requirement annually for all midwives. There are currently six LMCs who use this service for their clients. The facility manager has a system to annually ensure the midwives' APCS are current. The maternity healthcare assistants receive specific training which includes observations and monitoring, breast feeding advice and support, when to contact the LMC, administration of medication, emergency care, how to manager admissions and assist with transfers and other training requirements. Work instructions for all activities are documented and each staff member has a job description. There is an annual appraisal process for staff.</p>
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<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented staffing policy on staffing mix that covers the contract requirements and includes the rationale for determining staffing levels and skill mixes to provide safe service delivery. The policy is currently being reviewed. The clinical manager is responsible for the rostering of staff. There is a four-week rolling roster with set duties for staff. There is a separate roster to cover the maternity annexe twenty-four hours a day and seven days a week. There is a casual staff available if and when required. The minimal number of staff is provided during the night shift. There is a staff member trained in first aid on every shift. There is an on-call system after hours. The clinical manager is currently on call seven days a week, twenty-four hours a day.</p> <p>The maternity service has a maternity healthcare assistant on call twenty-four hours a day in the event of a lead maternity carer (LMC) bringing a woman in to labour and birth at this service or when a woman is being transferred from the DHB for the postnatal stay. The LMC is ultimately responsible for her client when in the service. The LMC is on call twenty four hours a day so staff can call anytime. The registered nurses and maternity healthcare assistants at Waihi Hospital are trained to assist in any obstetric emergencies/events should this occur. There are seven midwives with current access agreements who use this facility for their women. There is always a midwife on call should a woman arrive who is not booked with a midwife.</p> <p>Family interviewed and observation during the audit confirmed that staff are providing services required of them.</p> <p>The prospective provider stated that the staffing ratios will not change although more registered nurses will be required as resident numbers increase. The diversional therapist has just resigned and the position has been advertised however, the new prospective providers have requested that the facility manager does not employ a replacement immediately as they wish to make provision to increase the hours for activities as part of the employment process. The service is adequately covered for activities at the time of the audit and cover has been arranged until the new diversional therapist appointment is made.</p>
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<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site. The facility manager interviewed stated that the archived records are currently been refiled to allow for a more readily retrievable data cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>PA Moderate</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC (Disability Support Link – DSL) and the GP for residents accessing respite care. Also the GP residents admitted are either referred by the DHB or by the GPs in the community. Full information is required from wither source prior to admission. Criteria for entry is documented and the GPs visit their residents while in the service and all visits are documented.</p> <p>Notification of imminent entry to the maternity annexe was given to the facility by the LMC. The maternity healthcare assistant prepares the birthing annexe and appropriate room for the client. The criteria for entry for the primary maternity service is that clients are low risk and meet the requirements of Section 88. This was the responsibility of the LMC prior to completing the booking form for the client.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic</p>

		<p>detail, assessments. Not all residents' files had a signed admission agreement in accordance with contractual requirements. The auditor at the time of audit was unable to verify that all service charges comply with contractual requirements due to the unavailability of some signed admission agreements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The clinical manager interviewed stated that the facility does not use the DHBs 'yellow envelope' system but provides all documents required to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed good communication between the facility, acute setting, resident and family. Family of the resident reported being kept well informed during the transfer of their relative.</p> <p>The LMC interviewed stated that clients were discharged with appropriate care and education to ensure a safe transition home. A discharge checklist is used for the mother and baby to ensure the discharge was planned and coordinated in a safe manner. An external transfer in an emergency is managed efficiently as required with the staff assisting as needed. If a woman is transferred to the DHB a transfer form is completed with all relevant client information. A record is documented in the maternity register maintained.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care but not all medication sighted at time of audit was stored securely.</p> <p>A safe system for medicine management (using a paper- based system) was observed on the day of audit. The staff observed demonstrated</p>

		<p>good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management but not all residents had an identifying photo on their medication drug chart. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. There were no controlled drugs stored in the maternity annexe.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>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. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, are current and comply with guidelines. Not all medication administered to the baby by the lead maternity carer midwife is appropriately prescribed and recorded.</p> <p>There were four residents who were self-administering medications at the time of audit. Appropriate processes are not always followed. There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The food service is provided on site by one of two cooks and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns. The current menu was last reviewed by a qualified dietitian in May 2016. Recommendations made at the time have been implemented. The</p>

		<p>facility manager and cook interviewed stated that they are currently developing a new menu and aware that the menu will need to be reviewed by a dietitian.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. Food was observed during the audit to not always be stored appropriately. The facility manager interviewed stated that the rest home dishwasher in the kitchenette is currently broken, the facility is awaiting for a commercial dishwasher to be approved, and in the interim, the care staff are washing the dishes by hand (see criterion 1.4.2.1). Not all kitchenette fridges in the facility are being monitored appropriately.</p> <p>The service operates with an approved food safety plan and registration issued by the Hauraki district council which expires 13 June 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Women in the maternity annexe were provided with choices of food and a menu was reviewed.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local DSL (Disability Support Link) needs assessment co-ordination team is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for</p>

		<p>reassessment to DSL is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p> <p>The LMCs are responsible for ensuring their clients are appropriate to labour and birth in a primary birthing facility as per the Section 88 guidelines. This is also the case when a woman is transferring to this facility from the DHB for postnatal care and management.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. Residents have interRAI assessments completed by one of the six trained interRAI assessors on site. Not all interRAI assessments are up to date (see criterion 1.3.3.3). Residents and families confirmed their involvement in the assessment process.</p> <p>The LMCs are responsible for all assessments of the mother and baby through all stages of service delivery. Care plans for the mother and/or the baby are developed to reflect the assessment findings.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, nursing, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Not all residents had a social activities profile completed (see criterion 1.3.7.1). Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>The maternity records reviewed contained the daily assessments of the</p>

		LMCs and described the interventions required to achieve the documented outcomes for the mother and baby.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Ten Residents files were reviewed at the time of audit and included residents receiving respite and GP medical care. Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. There are four GP's who belong to one of two medical centres that support the facility. The residents admitted to the facility have continued to stay with one of the four GP's that supported them when living in the community. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is acceptable. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. Activities for residents occur in the rest home wing but do not occur for residents in the hospital wing (see criterion 1.3.7.1).</p> <p>For the maternity annexe the healthcare assistant interviewed confirmed that care is provided as outlined in the documentation reviewed for the mother and baby. The partner interviewed felt they had been involved in their care planning and delivery process.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	PA Moderate	<p>The activities programme is provided by an activities co-ordinator who has been in this role for two and a half years and is retiring in one week. The facility manager is advertising for a trained diversional therapist holding a national Certificate in Diversional Therapy (refer to 1.2.8). Residents are supported Monday, Wednesday and Friday from 8.30am to 4.30 pm. The activities co-ordinator is supported by networking with other facilities activities staff within the community once a month. The facility manager interviewed stated that in the interim until a diversional therapist has being appointed the current activities co-ordinator will be staying on as casual and the previous activities co-ordinator will also be</p>

		<p>supporting the residents at the facility.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements, not all social assessments have been completed. Activities that residents are partaking in are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly by the activities co-ordinator.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The rest home has an 'Old Codgers club' which is a room set up and run by the male residents in the rest home. There is one resident in the rest home who has his own vegetable garden that he tends to daily. Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings. Residents and families interviewed confirmed they find the programme very interactive in the rest home but the residents and families in the hospital wing reported that, although regular entertainment occurs on a monthly basis, there is otherwise no daily activities of interest provided. The activities co-ordinator and facility manager interviewed confirmed that activities are not occurring in the hospital wing for residents.</p> <p>Each client's room in the maternity annexe contains a television, which has designated DVD channels that can be used to run educational material for new parents. Pamphlets and resources are available throughout the annexe for parents to access. The maternity healthcare assistants can demonstrate baby bathing, safe sleeping and techniques and positioning for promoting successful breastfeeding. The woman interviewed was pleased to have some additional support and refresher of new born cares for her baby and for breastfeeding.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Not all six-monthly evaluations were sighted. Where progress is different from expected, the service responds by initiating changes to</p>

		<p>the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>All clinical records reviewed in the maternity annexe confirmed evaluation of service delivery plans took place daily by the LMC. This included evaluation of the baby to ensure new-born behaviour was observed. Ongoing evaluations occurred with each point of contact with the mother and the baby. Discussions occurred between the maternity healthcare assistant and the LMC.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctors', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to speech language therapist, mental health services for the older person, and geriatrician. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p> <p>Clients admitted to the maternity annexe for postnatal care stay approximately forty-eight hours. For clients that required a longer stay this was arranged following discussion with the client, the LMC and the facility manager. A referral is required to the DHB should a woman be in labour and needs to transfer for one reason or another. The Section 88 referral guidelines are used appropriately as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	FA	<p>Documented processes for the management of waste and hazardous substances were in place including segregation of waste, recycling and detailing procedures for blood and bodily fluids management and</p>

<p>harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>disposal.</p> <p>Chemicals were seen stored in locked areas around the facility although most were stored near the maintenance room. Contracted representatives ensure the stocks are replenished and that supplies are adequate for the service. An external company is contracted to supply and manage the majority of chemicals used for the cleaning and the laundry. The company provides relevant training for staff. Material datasheets were available for the chemicals provided and were accessible to the staff. Staff interviewed knew what to do so should any chemicals spill or an event occurred and stated they would report any related incidents in a timely manner. No spills have been reported.</p> <p>The maternity service has resources for cleaning the birthing rooms and individual client rooms when clients are discharged. The LMCs use disposable birthing packs and instruments. Oxygen and nitrous oxide cylinders are checked before and after a birth. Additional stocks are available and stored appropriately.</p> <p>There is provision and availability of personal protective equipment (PPE) and clothing and staff were observed using this including gloves, masks, face shields and plastic aprons.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The building has a current building warrant of fitness which expires 24 April 2019.</p> <p>There is a process to identify and manage maintenance both long term and reactive. Electricals safety testing occurs annually by a contracted company who provides an asset register of all equipment tested and tagged. Clinical equipment is tested and calibrated by an approved provider at least annually.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip, the correct use of mobility aids and walking areas are not cluttered. The facility has ample storage space for all equipment. Regular environmental audits sighted identify that the service actively works to maintain a safe environment for residents, visitors and staff. A maintenance person has been appointed</p>

		<p>to this role and is part of the newly established health and safety committee for this service. The maintenance person interviewed has already set up appropriate checking systems and was well informed about health and safety legislation.</p> <p>Outdoor areas have appropriate seating and shaded areas which are easily accessible for all residents including wheelchair access. The facility has large grounds and a groundsman is contracted to undertake this role.</p> <p>Interviews with residents and family members confirmed the environment is suitable for their needs.</p> <p>The rest home kitchen was sighted on the tour of the facility. When the temperature monitoring records were sighted it was observed that the dishwasher was demonstrating variable temperatures. When following this up the staff were seen to be washing and drying the dishes after the midday lunch. The domestic dishwasher installed was not functioning and this had been recorded in the maintenance book and was being actioned by the facility manager.</p> <p>The prospective provider proposes to improve the entrance to the facility and to make some improvements to the landscaping of the grounds. More seating is planned for the grounds. The provider interviewed also discussed the potential for the West Wing which is currently designated for long term rest home level residents. The prospective provider will apply to HealthCERT for these to be 'swing beds' (suitable for both rest home and hospital level care). The prospective provider has a planned teleconference with the maternity services portfolio manager next week to discuss the primary birthing contract and potential of the service.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is a mix of toilet and shower facilities. This includes rooms with ensembles and several additional toilets and showers. An adequate number of accessible bathrooms and toilets are identified throughout the facility and all are in close proximity to the residents' individual rooms. Staff and visitor toilets are available and are separate from residents' toilets. Appropriately secured and approved handrails are provided in the toilet shower areas and other equipment/accessories are available to promote residents' independence. Privacy is maintained throughout</p>

		the facility.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms were observed to be personalised for each resident by family and staff. Some have their own furnishings, photos and other personal items displayed.</p> <p>There are five single rooms in the maternity annexe two with ensuite bathrooms.</p> <p>The hospital is a mixture of large single rooms and shared four bedded rooms. Most have only two residents, at the most, in each room. The rest home and west wing are all individual rooms of generous proportions. Each room allows for ease of movement and adequate personal space to allow residents to move around within the bedrooms safely including with the use of mobility aids.</p> <p>There are areas for safe storage of mobility aids such as walking frames, hoists and wheel chairs. Some residents have their own total mobility scooters. There is provision for charging batteries as needed. Staff and residents reported adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are a number of communal areas available in each area of service delivery for residents to engage in activities. There is a spacious lounge set up as a 'Men's room' as part of the activities programme. The dining and lounge areas are spacious and enable easy access for residents and staff. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely. There is also one lounge used as a quiet lounge and one lounge that is set-up for the church service which is held weekly.</p> <p>The maternity annexe has a large lounge/dining room which is homely and comfortable for women and their partners to relax. Women can choose to have their meal in the dining area or in their own room.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>All laundry is undertaken on site in a dedicated laundry; this includes residents' personal items. Some family members undertake some of</p>

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>their relative's laundry by choice. Family members interviewed reported the laundry is managed well. The laundry is currently managed by dedicated laundry staff. The processes were observed and were seen to meet good practice. Laundry staff were able to demonstrate that they follow procedures on washing and drying cycles, dirty and clean flow, handling of soiled linen and have been trained to manage chemicals. The laundry staff are using washing powder now not liquid products. A contracted service provider is monitoring the products for effectiveness. Any bulk supplies are stored in a locked cupboard which is clearly sign posted.</p> <p>All cleaning chemicals are stored in labelled bottles and the cleaning trolley is stored in a locked room when not in use. Cleaning and laundry processes are also monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides the facility in preparation for any disasters and described the procedures to be followed in the event of a fire or other emergency. The facility has a working relationship with two DHBs including for emergency transfer of residents/clients and preparedness. The current fire evacuation plan was approved by the New Zealand Fire Service 12 June 2000. An email was sent on the day of the audit to verify this date. Trial evacuations take place six monthly and a record is kept of staff that attend to ensure all staff attend one practice annually. The last fire drill was 20 August 2018. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. The hospital boiler is well maintained and checked regularly. If the boiler temperature is too low or too high an alarm activates. Double sensors have been installed and pressure relief valves. Maintenance personal are summoned if the alarm sounds. This is displayed outside the reception.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including water, blankets, food stores and torches and other aides were available. A gas barbeque is available to meet the needs of the number of residents.</p>

		<p>Nurse call bells alert staff to residents' requiring assistance. Display boards were sighted in the rest home and the hospital.</p> <p>The facility call bells are checked regularly and response times are audited. There are call bells in the maternity annexe and an emergency bell that when activated rings in the hospital in several places to alert staff that assistance is required.</p> <p>The facility has external sensor lighting around the building. Staff are advised to call the police if they have any concerns. The staff on afternoon and night shifts check the building through the shifts ensuring doors and windows are securely locked. The maternity annexe is locked at night time at a certain time. Visitors or women in labour can ring the outside bell and the contact number is available to the facility if needed. A security company is contracted and does rounds throughout the night of the building and grounds. Staff interviewed are satisfied with the present security system in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The residents' rooms and communal areas have opening external windows. Heating is provided by the boiler supply heating system for the total facility. Radiator heaters are connected to this source and the temperature is mostly well maintained. The rest home lounge is a large area to heat. A heat pump has recently been arranged to provide additional heat.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the GP and pharmacy. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical manager, facility manager and discussed at the monthly registered nurse and three monthly care staff meetings.</p>

		Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. 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 responsibilities.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for two months. The IPC coordinator was not available at the time of audit for interview. The facility manager interviewed stated that the IPC coordinator will be booked into complete training in infection control. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The clinical manager interviewed confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2018 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and

		<p>evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. For example, the community had an increase in flu over the winter period, and the facility discussed with staff the importance of infection control and handwashing, extra signs and PPE personal protective equipment was placed at entrances to the facility.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers and graph results are also put on the noticeboard in the staff room each month. Trends are identified from the past year and this is reported by the IPC/registered nurse and reported to the clinical and facility manager and all staff. Twenty two (22) residents in April 2018 consented to the flu vaccine.</p> <p>The facility has had a total of 37 infections since January 2018 to July 2018. Three residents have been identified with nine of the 37 infections due to co-morbidities. The three residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. The clinical manager interviewed stated that the facility has not had an infection outbreak in the last 12 months. Data is</p>

		not benchmarked.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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 coordinator provides support and oversight for enabler and restraint management of the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities. The clinical manager has been the restraint coordinator for over ten years and has just orientated a registered nurse to this role.</p> <p>On the day of the audit four residents were using a restraint and one resident was using an enabler. Restraints are used as a last resort or when all other alternatives have been explored. This was evident on review of the restraint approval group minutes and records reviewed of those residents who have approved restraints and from interviews with the clinical manager. The newly appointed restraint coordinator was not available for interview during the audit.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	FA	<p>The restraint approval group is made up of the clinical manager, the registered nurse restraint coordinator and the general practitioner. The group are responsible for the approval of the use of restraints and restraint processes as defined in policy. It was evident from the review of meeting minutes, review of residents' records and interview with the clinical manager that there are lines of accountability and that all restraints have been approved and the overall use of restraints is being monitored and analysed. The care plans reviewed included documented restraint use and any risks associated, if applicable.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint are documented on an assessment form that includes all requirements of the standard. The initial assessment is undertaken by a registered nurse. Input of the family/whanau is sought whenever possible. The clinical manager</p>

		described the documented process. The GP signs off the final decision on the form provided. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who are using a restraint and all were signed appropriately.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>Restraint monitoring forms are used to record each episode of restraint use. When restraints are in use, hourly monitoring occurs to ensure the residents' needs are being met. The monitoring form is kept in the resident's record and is used by the restraint coordinator for monitoring usage and assessing conformity to the policy. The four restraints used are bedrails. It was seen that all processes ensure dignity and privacy is being maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. Restraint will be discussed at the newly formed health and safety committee meetings. Staff have received training in the organisation's policy and procedures and in the safe application of restraint, as well as positively supporting people with challenging behaviours. Staff interviewed understood the use of restraints is to be minimised and how to maintain safe use was confirmed.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of resident's records evidenced the individual use of restraints is reviewed and evaluated monthly by the restraint group and six monthly as part of the interRAI re-assessments, with input from family if possible, and documented evaluations by the GP. The evaluation meets the requirements of the standard. Policy and procedures were followed by staff and documentation was completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use	FA	The restraint committee review all restraint use monthly which includes all the requirements of the standard. Minutes of the group meeting

of restraint.		confirmed analysis and evaluation of the amount of and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use and appropriateness of restraints. Restraint use is reported to the quality meetings and is an item on the meeting agenda sighted. Any changes to policy, guidelines, education and processes are implemented if indicated.
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	<p>PA</p> <p>Moderate</p>	<p>All residents and family interviewed stated that they were provided with an information pack on admission providing information about the admission agreement and requirements of entering the facility. At the time of audit, the facility manager had commenced an audit of signed admission agreements and availability of enduring power of attorney documents.</p> <p>One of the three files reviewed in detail using tracer methodology did not have a signed admission agreement; the resident was admitted in April of 2015. The facility manager has recently requested by letter that the admissions agreement be signed.</p> <p>The file review was extended to include another 18 residents' files. Of those 18 files reviewed, six residents admitted in January 2017, March 2017, May 2017,</p>	<p>Not all residents' files reviewed have an admissions agreement signed.</p>	<p>Ensure that all admission agreements are completed and signed by the resident if deemed competent or the enduring power of attorney (EPOA) to meet contractual requirements.</p> <p>90 days</p>

		<p>December 2017 and March 2018 do not have a signed admission agreement.</p> <p>Three of the 18 residents' files reviewed had signed admission agreements, but the admission agreement had not been signed within the required timeframes. One resident admitted in September 2017 did not have agreement signed until December 2017, one resident admitted in December 2015 did not have agreement signed until January 2016, one resident admitted in June 2017 did not have an agreement signed until August 2018.</p> <p>One resident admitted in February 2017 and paying privately due to not being eligible for assistance and one resident admitted to the facility in July 2018 do not have a signed admission agreement. The facility manager interviewed stated that the resident has recently been assessed as not competent to make an informed choice and family are awaiting documents from the GP so the EPOA can sign the admission agreement.</p> <p>One resident admitted in February 2014 had an admission agreement signed by the enduring power of attorney, but it was not dated when signed. The facility manager has recently signed the admission agreement and had dated this as August 2018. The facility manager signed and dated the admission agreement (August 2018) in the provider section as she was not the facility manager when the resident was admitted.</p>		
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<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA Low</p>	<p>It was evident from staff interviewed and observation of a medication round that staff knew the residents well. Family/whanau and residents interviewed stated that they were happy with the care and communication provided. Seven of 22 residents' medication drug charts sighted did not have a photo to support identification and administration of medication to the right resident.</p> <p>Five client and five baby medication records were sighted in the primary maternity service. The client records were completed to a satisfactory level. Vitamin K prescribing and documentation of administration for babies was not completed on a separate medication record.</p> <p>Medication for the hospital was observed to be in a locked trolley in a locked room, the rest home medication was observed to be in a locked trolley but in an unlocked room. The rest home nurses' station/medication room internal door to the resident's dining room and lounge was able to be shut but did not have a lock. There was also an external door (that leads outside) from the nurses' station that was observed to be open and accessible to the public. On day one of the audit, maintenance personnel put a keypad lock on the internal door and has modified the lock to the external door so that both doors now lock. The auditor checked on two occasions after both doors had been fixed and found the rest home nurses' station/medication room to be locked and medication secure.</p>	<p>Not all resident's medication drug charts had a photo to support identification and administration of medication to the right resident.</p> <p>Vitamin K prescribing and administration after the birth with consent of the parents is currently documented on the client record and on a separate medication record for the baby.</p> <p>Not all medication is stored securely.</p>	<p>Ensure photographs of residents are placed on all medication drug charts and dated to acknowledge correct identification of the resident.</p> <p>Develop and implement a medication record for the baby with the appropriate information required.</p> <p>Ensure that all medication is stored securely to meet best medication practice and guidelines.</p> <p>90 days</p>
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<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>At the time of audit, there were four residents self-administering medications. In discussions with the residents and staff it was evident that the four residents were competent to do so. One of the four residents had an assessment completed to assess for competency of self-administration of medication but this was last reviewed on the 25 February 2016. The resident chooses not to use pre-packaged medication. Three of the four residents self-administering medications did not have a completed assessment for competency. The GP visiting on the day of audit completed three of the four competency assessments, the three residents are deemed competent to self-administer medication. Evidence was provided to show three-monthly GP reviews that included review of the resident's medications. Signing sheets were sighted for all four residents and staff interviewed stated that they ask the residents at the time of the medication round if they have taken their medication. All four residents self-administering medication do not have access to or store their medication in a secure location in their bedrooms.</p>	<p>Four of four residents self-administering medication did not have an assessment to show competence or the competency assessment was overdue. Four of four residents did not have their medications stored in a locked box.</p>	<p>Provide evidence that all residents who are self-administering medicines are meeting the facility's policy requirements to do so safely.</p> <p>90 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and</p>	<p>PA Low</p>	<p>Food procurement, production and preparation comply with current legislation and guidelines. The cook interviewed was aware of the guidelines. Not all food in the freezer and chiller of the main kitchen had</p>	<p>Not all food stored in the chiller or freezer in the main kitchen was stored appropriately.</p>	<p>Ensure that all food is stored as required by the food safety plan.</p>

disposal comply with current legislation, and guidelines.		food covered and/or dated. On the day of audit, there was cooked bacon in the freezer with a date but no label, there was desert chilling in the freezer covered with no label or date, fish defrosting for lunch menu was in the chiller not dated, covered or labelled.		90 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>All residents have individual, detailed and client specific initial care plans and long-term care plans. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and family members interviewed stated that they were very happy with the care provided. There are six registered staff trained in interRAI, which includes the clinical manager. Three registered nurses interRAI trained have left the facility since January 2018. The clinical manager interviewed stated that they have access to only one laptop computer that holds a license agreement to complete the interRAI assessments. Currently there are four residents who do not have an up to date interRAI assessment. Three interRAI assessment were due in April 2018 and one in July 2018. One interRAI assessment was due 13 August 2018 and remains within the acceptable timeframe. The facility is awaiting confirmation of level of care from DSL for one resident admitted June 2018 who continues to be supported by the mental health team. The facility is awaiting the transfer of one resident's file (an inter NASC transfer) and notification of level of care. The resident was assessed</p>	<p>Four residents did not have an up to date interRAI assessment, two residents initial interRAI assessments were not completed within the required timeframes</p>	<p>Ensure that all interRAI assessments are completed with the required timeframes.</p> <p>180 days</p>

		<p>by DSL in July 2018 and admitted to the facility initially as a GP acute resident and is paying privately. One resident does not require an interRAI assessment as they were currently admitted for respite care.</p> <p>There are a further two residents admitted to the facility who had an initial assessment and care plan completed and have an up to date interRAI assessment but the initial interRAI assessments were not completed within the required timeframes. One resident admitted April 2017 did not have an initial interRAI assessment completed until December 2017, one resident admitted June 2017 did not have an initial interRAI assessment completed until October 2017.</p>		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Moderate</p>	<p>Residents and families confirmed their involvement in the assessment process and care provided in the rest home wing. The activities co-ordinator interviewed stated that activities for residents occurs in the rest home but does not occur for residents in the hospital wing. Five of ten residents' files were reviewed (four resident files in the hospital wing and one resident in the rest home) one resident admitted in February 2014, April 2015, December 2015, November 2017 and August 2018 did not have a completed initial social profile and assessment.</p>	<p>Not all residents admitted to the facility have a social profile and assessment completed. Residents admitted to hospital level care are not supported with activities.</p>	<p>Provide evidence that all residents are supported with activities that are meaningful for each individual resident and each resident has a social profile and assessment completed.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p>	<p>PA Low</p>	<p>It was evident from staff interviewed that they knew the residents well.</p>	<p>Not all long-term care plans had evidence of a six-monthly</p>	<p>Provide evidence that all long-term care plans are</p>

<p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>		<p>Family/whanau and residents interviewed stated that they were happy with the care and communication provided. Short term care plans for infections and wounds are evaluated and signed of when completed and acknowledged in the long-term care plans. All residents had a long-term care plan. Seven of ten residents long term care plans did not have an up to date six monthly evaluation. The clinical manager was unable to provide evidence of previous six-monthly evaluations for all ten residents.</p>	<p>evaluation.</p>	<p>evaluated in a timely manner.</p> <p>180 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>The temperature records for the hot water monitoring in the rest home kitchen at the tap and for the dishwasher were reviewed. It was observed that the dishwasher temperatures had been variable for a period of time. Staff were observed not using the dish washer. Staff responsible stated they had reported this to management. The facility manager stated that a replacement dishwasher was currently being sourced.</p>	<p>The domestic dishwasher in the rest home is not functioning and staff are required to wash and dry the dishes by hand. A new commercial dishwasher has been quoted for and the facility manager is awaiting replacement approval.</p>	<p>Ensure an appropriate water temperature-controlled dishwasher is installed and used in the rest home kitchen.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.