

# Masonic Care Limited - Woburn

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## Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Masonic Care Limited
<b>Premises audited:</b>	Woburn Masonic Care
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 27 September 2018    End date: 28 September 2018
<b>Proposed changes to current services (if any):</b>	Total renovation of the facility to be undertaken in stages. Start date is April 2019 and it is estimated to take two years to complete.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	56



# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Woburn Masonic Care provides residential care for up to 57 residents who require rest home and hospital level care. On the first day of the audit there were 56 beds occupied. The facility is operated by Masonic Care Limited.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, a general practitioner and a physiotherapist.

A continuous improvement rating has been awarded relating to the service responding to meeting the demand for providing booked respite care.

Areas requiring improvement relate to performance appraisals not current for all staff, gaps in the provision of on-going training for staff including evidence of current food safety training for kitchen staff, monitoring of the effectiveness of cleaning and laundry processes and care plan support and interventions.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

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

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

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

The facility manager is responsible for the management of complaints and a complaints register is in place. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit

## Organisational management

<p>Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Masonic Care Limited is the governing body and is responsible for the service provided. A strategic business plan includes a purpose, vision, values and goals. There is regular reporting by the facility manager to the chief executive officer who reports to the board.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by a clinical nurse manager who is responsible for the clinical service.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Staff, resident, registered nurse (RN), health and safety and quality meetings are held on a regular basis.

There are policies and procedures on human resources management. Human resource processes are followed. An in-service education programme is provided.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The facility manager and clinical nurse manager are rostered on call after hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using integrated electronic and hard copy files.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist, a recreation assistant and several volunteers. Residents are provided with a variety of individual and group activities and maintain their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## Safe and appropriate environment

<p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents' bedrooms provide single accommodation. Residents' rooms have adequate personal space provided. Lounges, dining areas and alcoves are available. External areas for sitting and shading are provided. An appropriate call bell system and security and emergency systems are in place.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored. Personal laundry is washed on site, all other laundry is contracted out.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint policy reflects the requirements of the restraint minimisation and safe practice standard and identifies the use of enablers is voluntary and the least restrictive option to meet residents' needs. At the time of audit there were no residents using restraint and one resident using an enabler.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board, and the organisation's external infection control advisory service. The programme is reviewed annually.

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, analysed, trended, benchmarked 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)
<b>Standards</b>	0	42	0	1	2	0	0
<b>Criteria</b>	1	89	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	Woburn Masonic Care (Woburn) 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 occurring in August 2018.
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day to day care on an ongoing basis.

<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, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p> <p>Woburn has a facility independent advocate, who runs all the resident's meetings. Interview with the advocate verified knowledge of how to access additional support if required. The advocate verified managements prompt response to any areas of concern addressed by residents.</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 unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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>	FA	<p>The complaints policy, flow chart and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and forms available throughout the facility.</p> <p>The complaints register shows 25 written and verbal complaints have been received since the previous audit. The facility manager (FM) is responsible for the management of complaints. Documentation was reviewed for three complaints and evidenced Right 10 of the Code was met. Staff interviewed demonstrated a good understanding of the complaint process and what actions are required.</p> <p>The FM reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since their appointment in April 2018 and the CEO stated there have been no investigations between April and the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service</p>	FA	<p>Residents and family members 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</p>

<p>Delivery</p> <p>Consumers are informed of their rights.</p>		<p>discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms. Woburn has a resident's advocate, and residents and families interviewed confirmed their knowledge of who this was.</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 understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</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. Interviews with two residents who smoke, verified the service enables this to continue. A smoking room was sighted and included good ventilation to the outside.</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 is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training records reviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There are three residents in Woburn at the time of audit who identified as Māori. Evidence verified Woburn supports residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers.</p>
<p>Standard 1.1.6: Recognition And Respect</p>	<p>FA</p>	<p>Residents of Woburn verified they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and special needs were included in all</p>

<p>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>care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>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, physiotherapist, wound care specialist, community dieticians, services for older people, psycho-geriatrician and mental health services for older persons and education of staff. The 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 to attend external education through the Hutt Valley District Health Board (HVDHB) and access their own professional networks, such as on-line learning sites, to support contemporary good practice.</p> <p>Other examples of good practice observed at Woburn during the audit included a commitment to ongoing improvement in the care provided, evidenced by monthly meetings with specialist nurse practitioners to peer review the management of specific resident's care. There has been implementation of an initiative to improve palliative care services. Several caregivers have completed the level one palliative care course with planning in place to enable level two to be undertaken. Diversional therapy staff have attended a course on 'diversional therapy and palliative care'. This has resulted in staff setting up a palliative care toolbox, with aroma therapy oils and diffusers, massage oils, dry shampoos, for example, available to provide one to one care to residents</p>

		<p>in their last days of life.</p> <p>A weekly clinical review meeting between the clinical nurse manager (CNM) and the RNs was implemented, to ensure a comprehensive clinical handover which enabled all RNs to be updated on resident's care. This has resulted in improved continuity of care and keeping families up to date, especially over the weekends. The use of short 'toolbox' teaching sessions, to capture an opportunity for learning promptly when a knowledge deficit is identified is also a regular practise.</p>
<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 own or 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. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>A board at the entrance to the facility identifies key staff by photographs and a written introduction which also highlights their availability to always assist if and when required.</p> <p>Interpreter services can be accessed via Interpreting New Zealand when required. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</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>Masonic Care Limited is governed by a board of seven trustees who meet 11 times a year. A strategic business plan 2016-2021 includes a purpose, vision, mission, goals and operational development. Board meeting minutes evidenced reporting to the board against the four goals. The chief executive officer (CEO) reported the facility manager (FM) and the CEO meet several times a week to discuss activities relating to Woburn. The FM provides a monthly report to the board which includes a wide range of subjects including but not limited to facility performance, care reporting including falls, pressure injuries, complaints, staffing, investigations and any essential notifications. 'Quad' meetings are held two monthly which consist of representatives from the Masonic group's facilities. The meetings are chaired by the CEO and include a range of subjects including policy and procedure review and updating. Review of meeting minutes and interview of the FM confirmed this.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service.</p> <p>The FM, who is a registered nurse started in the position in April 2018. Prior to this appointment, the FM worked for a large aged care company as relieving educator/clinical manager for three and a half years and has management experience in another sector. The FM has a certificate in adult teaching in a tertiary setting</p>

		<p>and is interRAI trained. The FM is supported by a clinical nurse manager (CNM) who has been in the position since April 2018 and prior to that was the relieving FM for three months. The CNM has worked at Woburn for 20 years and prior to relieving manager was an RN/ team leader.</p> <p>Woburn is certified to provide hospital and rest home level care. On the first day of the audit there were 28 hospital level care residents, including one resident under an ACC contract and 28 rest home level care residents including three residents in for respite care. Woburn has contracts with the DHB for long term support chronic health conditions, short term residential care and aged related residential care.</p> <p>The FM reported HealthCERT has been notified of the change of FM and CNM since the previous audit.</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>	FA	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager be absent. The CNM fills in for the FM when absent and the FM fills in for the CNM. Support is provided from the board office and the village manager.</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>	FA	<p>A quality management plan guides the quality programme and included goals and objectives. Quality data is collected, collated and analysed, including audits, incidents/accidents, surveys and clinical indicators. An external company provides graphs, quarterly reports and benchmarking with other like facilities. Registered nurse, staff, health and safety, quality, infection control and resident meetings are held monthly. Meeting minutes reviewed confirmed this and evidenced reporting back to staff of corrective actions and trends as a result of analysing quality data. Staff interviewed confirmed this. The FM advised the Masonic group has appointed a quality manager who has oversight of all the facilities quality and risk management activities.</p> <p>Satisfaction surveys are currently with residents and families and the FM reported responses will be collated and corrective actions put in place at the end of September. Review of the surveys returned so far showed an issue around call bells response times. The FM has developed a corrective action around this and is currently monitoring response times.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures have been reviewed and are current. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate</p>

		<p>guidance for service delivery. The assessment and re-assessment policies include interRAI requirements.</p> <p>A risk management plan has a matrix and risk register that is comprehensive and includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risk. The hazard register includes actual and potential hazards and the actions put in place to minimise or eliminate the hazard. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is the FM and is responsible for hazards and demonstrated good knowledge. Staff confirmed they understood and implemented documented hazard identification processes.</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>	FA	<p>Staff document adverse and near miss events on an incident/accident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and analysed by the CNM and trends shared with staff through meetings. Families confirmed they are notified of incidents/accidents in a timely manner.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries and health and safety issues. The FM advised there have been no notifications of significant events made to external agencies since the previous audit and the CEO confirmed this.</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>	PA Moderate	<p>Policies and procedures relating to human resources management are in place and staff files evidenced the required documentation, apart from not all staff having a current performance appraisal.</p> <p>New staff are required to complete the induction programme. They are 'buddied' with an experienced caregiver with support from the CNL. The entire process, including completion of competencies, takes up to six weeks to complete and staff performance is reviewed at the end of this period and yearly thereafter. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Education programmes were sighted from May to December 2018 and for 2019. On-going training is the responsibility of the RN educator, who has been in this position since June 2018. The programmes evidenced the inclusion of all required training. It was difficult to determine what on-going training had been provided prior to the RN educators appointment. Certificates and current competencies for medicine management were sighted in staff files and attendance records are now held electronically. One hourly sessions are provided weekly for staff and review of documentation and interviews of staff confirmed this. The RN educator and FM reported once the required training and competencies have been completed, it is intended that the programme will consist of study days repeated several times per year. Tool-box talks are included at hand-over. All clinical staff, the activity person, administrator and maintenance person have current first aid certificates, and these were sighted in staff files. Review of kitchen staff files and interviews evidenced food safety training is not</p>

		<p>current.</p> <p>The Careerforce education programme is also available for staff to complete and staff are encouraged to do so. The FM, RN educator and an RN are the facility accessors. The FM reported the orientation programme is currently being reviewed and it is intended that this will result in new care staff attaining a level 2 qualification.</p> <p>Staff confirmed they have completed an induction, including competency assessments.</p>
<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>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes that is based on best practice. There are two RNs rostered on the morning and afternoon shifts. Six care staff are rostered on the morning shifts and four on the afternoon shifts. The minimum number of staff is provided during the night shift and consists of one RN and two caregivers. The FM and CNM work full time Monday to Friday and stated they review the rosters constantly and interRAI assessments are taken in to account. Six RNs are interRAI competent. The FM and CNM are rostered on-call after hours. Both GPs recently contracted to the service are on call seven days a week, 24 hours a day. A weekly clinical team review is held each Friday with the FM, CNM and the RNs on duty attending. The meetings provide information for the weekend RNs and include but not limited to residents of concern, the on-call staff including which GP, information relating to short term care plans and reminding the RN teams re using their clinical judgement. Care staff reported there are adequate staff available and that they can complete the work allocated to them. Residents and families reported there was enough staff on duty that provided them or their relative with adequate care. Review of rosters and observations during this audit confirmed staff cover is above requirements.</p>
<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>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. 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. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a 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>	FA	<p>Residents enter Woburn when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service, as requiring the services provided. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility</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>manager (FM) or the CNM. They are also provided with written information about the service and the admission process.</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 detail, assessments and signed admission agreements in accordance with contractual requirements.</p> <p>An initiative to expand the services available to meet the needs of families requiring respite care, is an area recognised as one of continuous improvement.</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>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the HVDHB 'yellow and black envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan 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 transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</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>	<p>FA</p>	<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.</p> <p>A safe system for medicine management using an electronic system, and a manual system for a respite resident, was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. 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. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</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</p>

		<p>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 electronic medicine chart.</p> <p>There were three residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the FM and CNM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders were not used at the time of audit.</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>FA</p>	<p>The food service is provided on site by an external contractor and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in August 2018. A food control plan is in place and registered with Ministry of Primary Industries (MPI).</p> <p>A verification audit was undertaken by an external agency in July 2018 and five areas with moderate findings were identified. Evidence is sighted of corrective actions being implemented. Interview with the FM verifies the FM was unaware of the findings in the verification audit. The plan expires 7 April 2019.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. 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, between 2013 and 2015. An interview with the kitchen manager identified kitchen hands have attended recent on-line training, however no record of this was available. The kitchen manager has no training in food safety (refer criterion 1.2.7.5)</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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</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 NASC is advised to ensure the prospective resident and their 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 reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the FM and CNM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Woburn are initially assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by six trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Plans reviewed did not always reflect the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information, particularly in relation to potential problems. All needs identified by the interRAI assessments however were reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>

<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>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care, except for those potential problems mentioned in criterion 1.3.5.2. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. 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.</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>	<p>FA</p>	<p>The activities programme is provided by a diversional therapist, with the support of a part time recreation assistant, a van driver, and several volunteers. A casual diversional therapist is available to assist if required. The programme runs Monday to Saturday.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activity programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include an exercise programme, church services in the chapel, physical and intellectual craft activities, and students from the local high school undertaking their Duke of Edinburgh award assisting residents. Van outings occur three times a week.</p> <p>In response to more activities required that are specific to men, a men's group is to start every Wednesday afternoon, with various activities for men, run by men. Men's group outings include visits to Southwards car museum, Te Papa and a visit to a local regional park, where the men will cook on a barbecue.</p> <p>Theme days are held on a regular basis the activities programme is discussed at the minuted residents' and family meetings and indicated residents' input is sought and responded to. A recent concern expressed around the time taken to answer bells is being addressed by management, based on an analysis of the cause.</p> <p>A weekly low stimulation programme is in place for residents who are less able to be involved in the main programme. The programme runs three times a week, in a separate area of the facility, and includes low stimulation activities, such as arts and crafts, puzzles, activities to enhance residents' opportunities to reminisce, themed 'fiddle boxes' and music from a music therapist.</p> <p>Activities for a resident under 65 years, support the resident's interest in sport, with Sky TV available. The resident is assisted by staff at Woburn to be involved in community events and family outings as requested.</p>

		Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN, except for that mentioned at criterion 1.3.5.2. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were consistently put in place when problems occurred. These are reviewed, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has two main medical providers, 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 older persons' mental health services. Referrals are followed up on a regular basis by the CNM or the GP. The resident and the family 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.
Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous	FA	Safe and appropriate waste management procedures including hazardous substances are in place and incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation, including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Staff have recently received training to ensure safe and appropriate handling of waste and hazardous substances. The laundry person demonstrated good knowledge concerning waste and hazardous substances.  Protective clothing and equipment including gloves, full face visor and disposable aprons were observed

substances, generated during service delivery.		appropriate to recognised risks.
<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>	FA	<p>A current building warrant of fitness was displayed that expires on the 6 May 2019. Although the building is of an older type, it is well maintained both internally and externally. The CEO stated the entire building is to be renovated in stages, commencing in April 2019 and will take two years to complete. The number of beds will remain the same. A preventive and a reactive maintenance programme is implemented. Hot water temperatures are checked at resident outlets monthly and documentation evidenced different rooms each month slightly exceed the recommend temperature. Review of corrective actions showed the plumber is called immediately to adjust the tempering valves to lower the temperatures. Testing and tagging of equipment and calibration of biomedical equipment is current.</p> <p>There are areas throughout the facility for residents to frequent. Gardens, lawns and outside furniture are available for residents to enjoy. Surfaces are flat internally and ramps with handrails lead to external areas. Residents were observed to easily manage with mobility aids.</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>	FA	<p>All rooms are single and there are adequate showers and toilets located throughout the facility. Locking devices with engaged and vacant signage were observed for privacy. There is a mix of bedrooms that share a full ensuite and bedrooms that have an ensuite consisting of a toilet and wash hand basin.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p> <p>Resident and families interviewed reported that there were sufficient toilets and showers and that they are easy to access.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the</p>	FA	<p>Rooms consist of a mix of smaller and larger rooms. Ten rooms have been approved to accommodate residents assessed as requiring hospital or rest home level care (dual purpose). Bedrooms are large enough to provide personal space for residents and allow staff and equipment to move around safely.</p> <p>Rooms are appropriately furnished and maintained. Residents interviewed spoke positively about their accommodation. There is room to store mobility aids.</p>

consumer group and setting.		
<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 numerous areas provided for residents to frequent for activities, dining, relaxing and for privacy. Residents, families and staff confirmed and observation evidenced these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</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>	PA Low	<p>Personal laundry and fitted sheets are washed and dried on site and all other laundry is carried out by an external contractor. The laundry person demonstrated good knowledge of laundry processes. Cleaning of the facility is completed by an external contractor. Observation during the audit evidenced the facility to be clean. Chemicals are stored securely in a sealed system and were in appropriately labelled containers. The company representative visits monthly and provides on-going training for staff. Cleaning equipment and linen bags are colour coded for different uses. There was no evidence of the cleaning and laundry processes being monitored for effectiveness.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The evacuation plan was approved by the New Zealand Fire Service on the 17 August 1919. Fire drills are completed six-monthly and the most recent one was held April 2018. There have been no building alterations since the previous audit. The emergency plan details emergency preparedness. Staff confirmed their awareness of emergency procedures. The orientation programme includes fire and security training. All required fire equipment has been checked and was current.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and a gas BBQ. Emergency lighting is battery powered. A call bell system alerts staff to residents who require assistance.</p> <p>The doors are locked in the evenings and sensor lights are situated externally. There is a bell system for visitors to ring after hours and a security service provides checks during the night. Staff also complete security checks.</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>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by hot water panel heaters. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. There is a designated area for anyone who smokes.</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>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at facility level with input from the FM and CNM. The infection control programme and manual are reviewed annually (last reviewed April 2018).</p> <p>The FM is the designated infection control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the quality coordinator and data entered an external health benchmarking framework and tabled at the infection control committee meetings and RN meetings. Staff are informed of any infection concerns at handover and by graphs in the staff room.</p> <p>The Masonic group quality manager is informed of any IPC concerns.</p> <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 related responsibilities.</p>
<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</p>	<p>FA</p>	<p>The ICC has appropriate skills, knowledge and qualifications for the role. The ICC has a post graduate certificate in infection control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from an external advisory service if additional support/information is required is also available. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection.</p>

organisation.		
<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 IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year 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, as was appropriate to the setting. 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	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions, through 'toolbox' sessions. Education is provided by the ICC or the onsite nurse educator or quality coordinator. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in eye infections. Education was provided and colour coded flannels introduced. The incidence of eye infections subsequently reduced.</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</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC reviews all reported infections. Monthly surveillance data is collated and analysed to identify any</p>

infection control programme.		<p>trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked externally.</p> <p>An analysis of flu injection uptake by residents has identified a good response.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes a restraint and enabler definition, assessment and evaluation and complies with the requirements of the standard. The restraint coordinator is the RN educator. The RN educator reported the aim for Woburn is not to use any form of restraint. There were no residents using a restraint at the time of audit, and one resident using an enabler. Sensor mats, padded safety mats and low-low beds are used so that restraint is not required. Staff interviewed demonstrated knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have not received on-going education relating to restraint and enablers and restraint competencies were not current. (See criterion 1.2.7.5).</p>

## 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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	<p>On-going training is the responsibility of the RN educator, who was appointed in April 2018 and has a background as an educator for a large aged care company. The RN educator has developed education programmes from May to December 2018 and 2019 that cover all the required training for staff. It was difficult to determine what on-going training had been provided prior to the RN educator’s appointment. Staff files had no evidence of attending sessions and although there was a programme, it was confusing and difficult to know if the sessions had been provided. Staff confirmed they had not received training for the first half of 2018. Certificates and current competencies for medicine management were sighted in staff files and attendance records from July have been developed and held electronically. Subjects including but not limited to restraint training and competencies, cultural awareness, pressure injury, core education to meet the DHB contract, apart from wound management, have not been provided. Care staff interviewed demonstrated a lack of knowledge relating to recognising pressure injuries and the different stages. Currently one hourly sessions are being provided weekly for staff to ‘catch up’ on training and review of documentation and interviews of staff confirmed this. The RN educator and FM reported once the required training and competencies</p>	<p>Review of documentation and interviews of the FM, RN educator and staff evidenced there has been a lack of on-going training for staff prior to May 2018. Kitchen staff do not have current food safety certificates.</p>	<p>Provide evidence that all staff have received the required on-going training and have current performance appraisals.</p> <p>90 days</p>

		<p>have been completed, it is intended that the programme will consist of study days repeated several times per year. All clinical staff, the activity person, administrator and maintenance person have current first aid certificates, and these were sighted in staff files. Kitchen staff do not have current food safety certificates.</p> <p>Staff files evidenced performance appraisals were not current for eight staff members. An electronic register is held for all staff. The FM reported many of the performance appraisals were due prior to the FM being appointed to the position and staff files confirmed this.</p>	Not all staff have current performance appraisals.	
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>Six of 15 files reviewed did not address the potential problems identified in the assessment process and identify the strategies required to minimise or monitor these potentials, with the aim of preventing incidents occurring. This specifically related to pressure injury management, falls management and behaviour management. Prompt attention to managing the events after they occurred was evidenced in the implementation of short-term care plans</p>	Not all care plans reviewed described the required support or interventions necessary to achieve the resident's desired outcomes.	<p>Provide evidence that all care plans describe the required support necessary to achieve the resident's desired outcomes</p> <p>90 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes</p>	PA Low	<p>Apart from fitted sheets, all laundry is contracted to an external company. Personal laundry is laundered on site. Cleaning is undertaken by an external contractor. There was no documentation available to evidence that the facility or the external contractors are monitoring the effectiveness of the cleaning and laundry processes.</p>	Documentation was not available to evidence the cleaning and laundry processes are monitored for effectiveness.	Provide evidence that the cleaning and laundry processes are monitored for effectiveness, on a regular

are monitored for effectiveness.				basis. 30 days
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.1.4 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.	CI	In April 2018 a review of enquiry records identified ten recent enquiries from family members wanting to book a bed for respite care, to enable the carer to plan a holiday. Woburn was unable to meet that request as they could only offer respite care if a long-term care bed was available. The service did not have a dedicated respite bed, that could be booked. Following consultation with the DHB and the NASC, a high level of need in this area was determined, and it was predicted a high level of occupancy would prevail. A room was refurbished to meet the needs of residents requiring respite care and set aside for this service. The allocated respite room is now available. It is in high demand and enables families to book holidays and take advantage of cheaper holiday costs, rather having to take a holiday and book at the last minute when a room became available.	Woburn has put in place an initiative where an allocated respite bed is available, to enable families to book the bed in advance and access it at a time that is convenient for them. This has allowed a more responsive service that better meets the needs of respite residents and has improved satisfaction in this are for both these residents and their families.

End of the report.