

Wellness Enterprises Limited - Raglan Rest Home and Hospital

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:

Legal entity:	Wellness Enterprises Limited	
Premises audited:	Raglan Rest Home and Hospital	
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 31 January 2019	End date: 1 February 2019
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:	27	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

Raglan Rest Home and Hospital provides rest home and hospital level care to a maximum of 36 residents. This planned certification audit against the Health and Disability Services Standards and the provider's contract with Waikato District Health Board (WDHB) was the first audit conducted since the service was purchased by Wellness Enterprises in April 2018.

The audit process included the review of policies and procedures, review of resident and staff files, observations, interviews with residents and their families, management, staff, the contracted physiotherapist and a general practitioner.

This audit did not identify any areas requiring improvement and confirmed that the issues identified at the provisional audit prior to purchase have been fully resolved.

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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Residents 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 and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provided residents and families with the information they need to make informed choices and give consent.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. There was 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 the resident's needs.

The complaint management system complies with legislation and this standard. A complaints register is maintained and complaints are resolved promptly and effectively. There have been no serious complaint investigations under the ownership of the new provider.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents 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 guide all areas of service delivery. Those reviewed were current and showed evidence of being controlled documents.

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/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 were reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely 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. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Waste and hazardous substances are well managed. The buildings, chattels and equipment are being well maintained, replaced or upgraded as necessary. There was a current building warrant of fitness. Electrical equipment is tested as required. External areas are accessible, safe and provide shade and seating.

Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

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

Residents reported a timely staff response to call bells. Building and grounds security is monitored. Communal and individual spaces are maintained at a comfortable temperature.

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 service meets the requirements of this standard. There were no restraint interventions in place and one resident was using an enabler on the days of audit.

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 trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control 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	45	0	0	0	0	0
Criteria	0	92	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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>Raglan Rest Home and Hospital 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 orientation process for all staff employed and in on-going training, as was verified in training records and the schedule.</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. All files reviewed had a signed admission agreement and consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to gain to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.</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>	<p>FA</p>	<p>During the admission process, residents 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 spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The Clinical Manager provided good examples of when they would involve Advocacy Services and/or encourage the resident and/or family to do so.</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>	<p>FA</p>	<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. The facility provides transport for community activities and community group visits. The local citizens club visit monthly for lunch and activities with residents. The local librarian visits for book club monthly as does the kindergarten and 'Mums and Bubs' group.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family members 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>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns.</p> <p>The complaints register reviewed showed that one complaint has been received since the new ownership and that actions taken, through to an agreed resolution with the complainant, are documented and were completed within a short timeframe. The owner/nurse manager (NM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received or investigated by the DHB or the Office of the Health and Disability Commission since the previous audit.</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. Admission packs have been re-provided to all residents by the new owners. The Code is displayed in the main corridor together with information on advocacy services, how to make a complaint and feedback forms are at reception.</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 have a private room.</p> <p>Residents are encouraged to maintain their independence by attending community activities and arranging their own visits to the doctor. Care plans 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.</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 needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Staff support residents in the service that 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 whanau. There is a current Māori health plan developed with input from cultural advisors. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents interviewed reported that staff acknowledge and respect their individual cultural needs including conversing in Te reo Māori with Māori staff members. Local kaumatua visit the facility fortnightly with a music group.</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. Residents' personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</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. 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.</p>

harassment, sexual, financial, or other exploitation.		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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	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, psychogeriatrician 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 staff were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The service provider has agreements with the Ministry of Health and Waikato DHB to provide services to people under 65 years, age residential care for hospital geriatric and rest home services, long term chronic health conditions, palliative care, respite/short term care, and a day activities programme. Raglan Rest Home and Hospital has a total capacity of 36 beds. On the days of audit there were 27 residents on site. Of these, 16 residents were receiving rest home level care and seven were receiving hospital level care. Two residents were on respite and two residents were under the age of 65 years (young people with disabilities). The organisation has a clearly described scope, direction and goals documented in its annual strategic and business plan. This is the first age care facility owned and operated by the Nurse Manager/owner (NM). This person is a New Zealand Registered Nurse with a Post Graduate Diploma in Gerontology and a certificate in public health nursing. The NM has held various clinical nurse and regional manager roles in residential disability and age care services. Interview and records reviewed showed that this person is maintaining essential skills and knowledge by attending regular professional development and

		industry conferences.
<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>The NM role is covered by the senior RN when needed, although the NM has not had any long term planned or unexpected absences since takeover in April 2018. The senior RN confirmed knowledge and acceptance of the arrangement. This person is sufficiently experienced having worked at Raglan Rest Home and Hospital for three years in a leadership role.</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>The new owner for Raglan Rest Home and Hospital has maintained membership with The Cavell Group, a group of other age care providers who developed and maintain a quality and risk system which includes a comprehensive set of policies and procedures. The policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. Control of these documents is moderated by all managers of the Cavell Group, who facilitate a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The quality system includes a schedule of internal audits, documentation and monitoring of any changes made as a result of an audit, management of incidents, including clinical incidents such as infections and complaints. Interview with the NM and the review of documents related to quality (for example, audit outcomes, results of incident data analysis and benchmarking across the Cavell Group) confirmed use of the system and a commitment to quality improvement.</p> <p>The staff interviewed demonstrated knowledge, understanding and involvement with quality and risk management activities. Month by month analytical reports on incidents/accidents are discussed at monthly staff meetings and graphs that showed how Raglan Rest Home and Hospital compares with the four other age care facilities in the group are on display in staff areas. This was confirmed by review of meeting minutes and visual inspection. Feedback about specific services is sought from residents and their family members. Resident satisfaction surveys are completed annually. The most recent survey from August 2018 showed no areas for concern,</p> <p>The NM is conversant with the Health and Safety at Work Act (2015) and has implemented its requirements. Review of the current risk management plan identifies all known risks and clearly described mitigation strategies.</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 accident/incident form. A sample of incidents forms from May to December 2018 reviewed showed these were accurately and clearly described, that family members are notified, and that the incidents are investigated when necessary. The NM reviews all incidents and follows up any improvements required in a timely. Monthly event data is collated, analysed and reported to the Cavell Group for benchmarking. These reports provide key information for discussion at staff meetings.</p> <p>On interview the NM demonstrated understanding of essential notification reporting requirements. They advised the DHB of a suspected infection outbreak in April 2018, but because no residents were effected, the conclusion was that staff contracted illness from food brought in.</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>	FA	<p>Policies and processes for staff management are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. A staff member who had previously worked at the home was complimentary of the orientation process. Other new staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The improvement required at the last audit about staff education in safe restraint use is now resolved. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Four RNs are maintaining annual competency requirements to undertake interRAI assessments. Each of the staff records reviewed contained evidence of required training attended and completion of annual performance appraisals</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. Although the ratio of hospital to rest home residents has changed to there being a majority of rest home residents (ie, less dependent residents), staffing levels have stayed the same. Care staff were very happy about this and reported staff morale as high. Residents and family members interviewed supported this. An afterhours on call roster of RNs and GPs is in place, with staff reporting that good access to advice is available</p>

experienced service providers.		when needed. Observations and review of a four-week roster cycle confirmed more than adequate staff cover has been provided. Absent staff are usually replaced by employed staff doing additional hours including the NM. At least one staff member on each duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage as required for hospital level care.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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 provider notes. This includes InterRAI assessment information entered into the Momentum electronic database. Records were legible with name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Disability Support Link (DSL) 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 DSL and/or the GP for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been available to them on admission. Files reviewed contained demographic detail, assessments and signed admission agreements in accordance with contractual requirements. This was a previous improvement identified at the provisional audit; this has now been rectified. All residents' admission agreements sighted were signed and dated. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow 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/whanau. 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 the transfer was planned and managed in a co-ordinated manner. Family of the resident reported being kept well

		informed during the transfer of their relative.
<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>	FA	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management 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>Medicines are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medication against the prescription. All medications sighted were within current use by dates. All eye drops and topical ointments had opened dates and use by stickers attached and were within use by date. This was a previous improvement identified at the provisional audit and has now been rectified. Clinical pharmacist input is provided weekly and as needed; this was verified at GP and RN interviews.</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.</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. Of a total of 18 medication charts reviewed, all had discontinued medication crossed out, dated and signed. The required three monthly GP review was consistently recorded on the medication chart.</p> <p>At the time of audit there were no residents self-administering medications.</p> <p>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</p>	FA	<p>The food service is provided on site by a qualified chef and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a nutritional consultant within the last 12 months. Recommendations made at that time have been implemented.</p>

<p>this service is a component of service delivery.</p>		<p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved safety plan registration issued by Waikato District Council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The chef has completed relevant food handling training, 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. 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. 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 Service 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 reassessment to the DSL is made and a new placement found, in consultation with the resident and whanau/family. There were no examples of this occurring. 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>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, 'BERG' assessment, and depression scale, as a means to identify any deficits and to inform initial care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by four trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service</p>	<p>FA</p>	<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 evidenced service integration with progress notes, activities notes, medical and allied</p>

<p>delivery.</p>		<p>health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed onto 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 to residents was consistent with their needs, goals and plan of care. 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 excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources were 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 an activity co-ordinator currently completing a diversional therapy qualification. The activity co-ordinator works Monday to Friday 9 am to 3.30 pm. There are various volunteers that assist with the activities programme throughout the week. A volunteer living close by attends at weekends.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly a part of the formal care plan review or sooner as needed. This was clearly documented in residents' files reviewed.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered, Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme enjoyable, varied and fun.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' 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. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for wounds and</p>

		weight loss. When necessary, and for unresolved problems, long term care plans are added to and updated, as verified by records reviewed and staff interviewed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<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 doctor', 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 physiotherapy, a wound specialist and district nursing. The resident and family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Appropriate signage is displayed where necessary. All staff who handle chemicals have completed safe chemical handling training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff.</p> <p>Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do in the event of a chemical spill.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>	FA	<p>A current building warrant of fitness expiring on 22 April 2019 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Testing and calibration of hoists and bio medical equipment occurs regularly. The testing and tagging of other electrical equipment was completed on 22 January 2019. Staff routinely inspect the environment to ensure it remains hazard free, and that resident's safety and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Residents and their relative's expressed satisfaction with the overall environment.</p> <p>Residents and staff interviewed confirmed understanding of the process for requesting repairs and</p>

		<p>maintenance and said they were happy with the response times. This was validated by review of the maintenance request logs, discussion with maintenance staff and inspection of the environment.</p> <p>The new owner has enhanced the environment with purchase of new furniture, installation of new corridor lighting and development of an outdoor pergola/shaded sitting area.</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>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes eight bedrooms with shared ensuite bathrooms and four communal bathrooms. Staff and visitors' toilets are separately designated. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p> <p>Hot water temperature monitoring is occurring as confirmed by interview, hand testing and review of documents. Temperatures are at or below 45 degrees Celsius from taps that are accessible to residents.</p>
<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>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is sufficient space in and around the facility to store mobility aids such as commode and shower chairs, wheel chairs and hoists. Residents and family members interviewed expressed satisfaction with the 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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents and families were observed to be accessing other internal and outside areas for privacy during visiting. Since takeover, a number of items of new furniture have been purchased. The furniture throughout the facility was in good repair and appropriate to the setting and residents' needs</p>
<p>Standard 1.4.6: Cleaning And</p>	FA	<p>All linen and personal clothing is laundered on site by the health care assistants who share the workload. The staff interviewed demonstrated knowledge and understanding about safe and hygienic</p>

<p>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>		<p>laundry processes, including dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. There is a small designated cleaning team who have been provided with training in safe handling of chemicals and general health and safety education, as confirmed in interviews with cleaning staff and review of their training records. Chemicals were observed to be in appropriately labelled containers and are stored in a lockable cupboard when not in use.</p> <p>Cleaning and laundry services are monitored through the internal audit programme. Results of the audits reviewed showed no areas of concern.</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>	<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 direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 03 May 2015.</p> <p>The improvement required identified at the provisional audit related to the frequency of trial evacuation drills has been resolved. An external fire consultant carries out onsite observations of drills and provides staff training. Records showed that two drills have occurred since April 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Sufficient supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the maximum number of residents (36). Water storage tanks are located around the complex, and there is a small generator on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. There is closed circuit television monitoring in the main thoroughfares of the building, which residents and their families are advised.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by a combination of radiators and panel heaters in residents' rooms and in the communal areas. There is a heat pump in the large lounge. All areas were well ventilated throughout the audit and residents and families said the home</p>

<p>ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>is maintained at a comfortable temperature during all seasons.</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 implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from clinical nurse specialists. 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 facility manager/clinical manager, owner, governing body and tabled at the RN, staff and quality and risk meeting. The committee includes the IPC coordinator, health and safety officer, and representatives from food services and household management.</p> <p>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>
<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>	<p>FA</p>	<p>The IPC coordinator has appropriate skills and qualifications for the role and has been in the role for one year. She has undertaken a post graduate paper in infection control and attended relevant study days and updates as verified in training records sighted. Additional support and information is accessed from the infection control team at Waikato 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 IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. This was verified through observation.</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</p>	<p>FA</p>	<p>The infection control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed 18 May 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 handwashing 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>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>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>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 evaluated to ensure it's relevant, current and understood. A record of attendance is maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about notifying staff and staying in their rooms if unwell and increasing fluids in hot weather.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator and Clinical Manager reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover to ensure quality intervention occurs.</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 all staff via regular staff meetings and staff handovers. Graphs are produced that identify trends for the year, and comparisons against previous years and this is reported to the facility manager/clinical manager, quality and risk, RN and staff meetings. These results are now being benchmarked externally within the Cavell Group.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>No residents were using restraint interventions on the days of audit. One resident uses a fall out chair as an enabler. Discussion with that person confirmed use of this was voluntary and at their request. The NM reviewed the people who were using bed rails and has systematically be able to remove these in agreement with the residents and their families. New restraint policies and processes are known and ready for use should restraint be required. The policies are in line with the standard. A new system for obtaining immediate approval, via teleconference is in place when needed.</p> <p>The improvement required related to quality review of restraint practices is now resolved. Records of</p>

		a comprehensive review discussion were sighted. Interviews with the staff RNs, HCAs and review of individual training records confirmed that education on restraint minimisation and safe practice occurs at orientation and at least every year after that.
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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.

No data to display

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.

No data to display

End of the report.