

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

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## Introduction

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

The audit has been conducted by 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>	Ngati Porou Hauora Charitable Trust Board
<b>Premises audited:</b>	Te Whare Hauora o Ngati Porou
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Hospital services - Maternity services
<b>Dates of audit:</b>	Start date: 1 April 2019      End date: 2 April 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	8



# 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

Te Puia Springs Hospital, otherwise known as Te Whare Hauora o Ngati Porou, provides in-patient and emergency medical care, rest home and hospital level (geriatric) care for up to 17 patients and for up to three maternity patients. The service is operated by the Ngati Porou Hauora Charitable Trust and managed by a chief executive and a hospital services manager. Staff and patients reported the value of the services available from this facility in such an isolated part of the country.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of patients' and staff files, observations and interviews with patients, management and staff.

Three areas requiring improvement at the certification audit relating to medicine management competencies, labelling of chemicals and fire evacuation trials have since been satisfactorily addressed. There were eight criteria in which corrective actions were identified during the surveillance audit. These related to issues regarding aspects of service delivery in the quality management system, the risk register, annual registrations of health professionals, training records and performance appraisals, the midwifery workload and clinical management, the activities programme, review of the menu plans and infection surveillance.

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

Patients are informed about the complaints process and information on their right to complain is readily available. A complaints register is maintained with complaints resolved effectively.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statements of the organisation. Reports on monitoring of the services is provided to the governing body each month. An experienced and suitably qualified person manages the organisation.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved at varying levels. Adverse events are documented with corrective actions implemented. Actual risks, including health and safety risks, are identified and mitigated for some areas of the service. Policies and procedures support service delivery, are reviewed regularly and were current.

The appointment, orientation and management of staff is based on current organisational policies and procedures. A systematic approach to identify and deliver ongoing staff training is in place. Staffing levels and skill mix meet the changing needs of patients.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Registered nurses are on duty 24 hours each day in the facility supported by care, allied health staff and a designated medical officer who is on call. The midwife manager is on call 24 hours a day, seven days a week for the primary maternity service provided. Women/wahine can be admitted at any time for an assessment and/or in labour or for postnatal care. Patients on admission to the service are admitted by a registered nurse. Initial assessments and a care plan are developed with the patient and the family/whānau. The patients are reviewed by the medical officer in a timely manner. When there are changes to the patient's needs a short-term plan is developed and integrated into the long-term plan for the long-term residential care patients. On call arrangements are in place. Shift handovers are provided between all shifts to guide continuity of care.

Patients' care plans are individualised based on the Needs Assessment Service Coordination (NASC) service information and from the interRAI assessments completed by the registered nurse. All patients' records documented identified needs, goals and outcomes when reviewed. Patients interviewed reported being well informed and involved in care planning and that the care was satisfactory. Patients are referred or transferred to other health services as needed with appropriate verbal and written handovers.

The daily activities for the long-term residential care and respite care patients is facilitated by ward staff. Both individual and group activities are provided. The staff ensure links with family/whānau and the community are provided as able. Parenting education for women and their partners is promoted by the midwife and staff at every opportunity in the maternity unit.

Medication administration is managed by staff who have been assessed as competent to do so. A safe medicine administration system was observed at the time of the audit. The midwife can prescribe within the midwifery scope of practice.

The food service is managed by experienced staff. The kitchen was well planned, clean and met food safety standards. Staff have completed food safety requirements. The service is working towards a food control plan which is to be audited this month. Patients verified they were pleased with the meals provided.

## 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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The building has a current warrant of fitness. There have been no structural changes to the building since the last audit.

An approved fire evaluation plan has been obtained and trial fire evacuations undertaken.

## 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 organisation has policies and procedures that support the minimisation of restraint. One restraint and one enabler were in use at the time of the audit. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The infection prevention and control programme is described within an applicable infection prevention and control policy and procedure manual. Requirements of the infection surveillance processes are described within these documents. Membership of an infection prevention and control committee that is responsible for assisting with implementation of surveillance processes was included in a committee meeting held February 2019. Staff observed demonstrated good principles and practice around infection prevention and control.

## 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	12	0	3	3	0	0
<b>Criteria</b>	0	32	0	5	4	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
<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/concerns policy and associated forms meet the requirements of Right 10 of the Code. This notes that a severity rating is attributed to the issue if it also involves an adverse event. Information on the complaint process is provided to patients on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that although 23 complaints were filed during 2018, and another nine for 2019 thus far, only one for 2018 and one for 2019 were from the hospital service. Two complaints are still under investigation. Records for a complaint lodged in January that is being managed by the hospital services manager (who was not available for interview) were unavailable. Actions taken, through to an agreed resolution, are documented and completed within the expected timeframes. Any required follow up and improvements have been made where possible.</p> <p>The quality coordinator is the complaints administrator and acknowledges each complaint; however, the relevant manager is responsible for the investigation process, the overall complaint management and the follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit. The service provider is awaiting the final letter from a complaint lodged with the Health and Disability Commission; however, this was in regard to services from one of the organisation's community clinics and not the inpatient service.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy and procedure that describes expectations around communication with patients/residents. Open disclosure was evident on completed adverse events forms. Updates in complaint related correspondence also demonstrated open communication processes occur. The patients interviewed are satisfied with the level of information provided to them and staff interviewed were aware of their responsibilities in ensuring patients and their family/whānau are fully informed.</p> <p>An interpreter policy notes patients'/residents' right to have access to an interpreter if this is needed and includes contact details of these services. There has been no requirement for interpreter services to be accessed. A senior staff person informed that approximately 50% of staff are fluent in te reo Maori and are able to assist people who identify as Māori and prefer to speak te reo, especially as most are tangata whenua.</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>	<p>FA</p>	<p>Te Puia Springs Hospital was built in 1903 and sits in the small rural township of Te Puia Springs on the east coast of the North Island. The hospital, alongside a range of other health services is operated by the Ngati Porou Hauora. Since 2011, Ngati Porou Hauora has come under the umbrella of Te Runanga o Ngati Porou, as one of its subsidiaries with Charitable Trust Status. The Trust has five board members and there is one current vacancy. A 2018 – 2021 business plan has a long-term goal and lists a set of dreams that include equitable funding for whānau, for the organisation to be a strong leader in indigenous and rural health in the health sector and for the next generation to live longer and better. This plan included a list of success measures against goals around rangatiratanga (leadership), whānau (people), mātauranga (quality), kaitiakitanga (infrastructure) and whai rawa (financial). Values are listed and described in Māori cultural terms and there are mission statements alongside each success factor. Operational plans sit within the business plan.</p> <p>A sample of monthly meeting minutes were viewed, as were copies of monthly reports from the chief executive, who attends the board meetings to present the reports. The documents showed adequate information to monitor performance is being reported. These include financial performance, emerging risks, quality and safety and a range of information and discussion papers. Examples of quarterly continuous quality improvement reports from the quality coordinator to the chief executive were viewed and summaries of these are presented to the board.</p> <p>Ngati Porou Hauora is managed by a chief executive who holds relevant qualifications and has been in the role for six years. During interview, the chief executive confirmed knowledge of the sector, regulatory and reporting requirements. Previous experience includes leadership and management positions within nursing, the planning and funding division of a district health board (DHB) and Ministry of Health. Responsibilities and accountabilities for the chief executive position are defined in an individual employment agreement.</p> <p>Hospital services are managed by a hospital services manager, who was absent on both days of the audit. There were reports that although this person is not clinical, they have had extensive management experience, including change management. As per the corrective action raised in 1.2.8, there is not currently a clinical manager employed by the service, although clinical support is being provided through the local DHB.</p>

		<p>Ngati Porou Hauora holds over 60 contracts to deliver a range of services through its seven community clinics and its hospital based in Te Puia Springs. This audit covered services at Te Whare Hauora o Ngati Porou, including maternity services, medical services and the rest home and hospital services covered under the Aged Related Residential Care Agreement Services with the local District Health Board. On the day of audit, four people were receiving long term hospital level aged care, three were receiving respite care, all under the aged care contract, and one person was receiving medical services. There were no patients in the maternity ward. The person receiving medical care was transferred out during the audit and one person receiving services was discharged.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>The organisation has a planned and documented quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, a regular patient satisfaction survey, monitoring of outcomes and review of clinical incidents including infections and restraint.</p> <p>A quality coordinator is currently undertaking the review of a range of quality and risk activities. Corrective actions and quality improvements are being implemented by the quality coordinator as far as possible. Plans are in place for quality and risk activities to be discussed at three key sets of meetings: the clinical governance group, the clinical advisory group and the health and safety team. Meeting minutes reviewed showed that there had been no meetings at which quality and risk were formally discussed since 2017. There was also evidence that there are some ad hoc reporting processes with some quality activities being completed by the hospital and others by the quality coordinator. Some essential gaps in the quality and risk management system, including around the internal audit schedule, were identified. Patient/resident and family satisfaction surveys are scheduled to be completed annually, including one for later in 2019. However, none occurred in 2018 and previous results that demonstrated quality improvement were unavailable. Corrective actions have been raised for criterion 3.5.7 regarding infection surveillance and reporting, and in criterion 1.2.3.5 for the need for aspects of service delivery to be integrated into the quality and risk management system.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements. Those reviewed are based on best practice and are progressively being reviewed every three years as they become due. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. There is a progressive move towards documentation becoming accessible only via the electronic system.</p> <p>The quality coordinator described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. This is occurring for risks identified through other quality improvement activities, such as following incidents or accidents, but not as a routine quality management process. A corrective action has been raised for criterion 1.2.3.9 as there is no risk register currently available for the management of potential and ongoing organisational risks.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident 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 quality manager and reported to the chief executive in quarterly reports. It was observed that some incidents specific to service delivery were not included in the analysed data reviewed. On investigation it was apparent that this was the result of responsibilities for quality improvement analyses being split between two people and the risks associated with this have been raised for corrective action under criterion 1.2.3.5,</p> <p>The chief executive and the quality coordinator described their awareness of essential notification reporting requirements. This was complemented by further information provided from a registered nurse/nurse leader from the local district health board, who is currently supporting the service provision at Ngati Porou Hauora. Documents sighted showed that a health, quality and safety commission investigation, following a reportable event in August 2018 that required a coroner's inquest, is still under investigation. The team advised that there have not been any other notifications of significant events made to the Ministry of Health, since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Human resources management policies and processes 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 implemented and records are maintained. Not all documents were available in the files of longer-term staff as there were different file requirements in place at that time. A corrective action has been raised as there is an absence of documents verifying the current registration of health professionals and their current scope of practice.</p> <p>A review of staff orientation has occurred. Staff orientation processes included all necessary components relevant to their role. Staff reported that the orientation process provides them with sufficient preparation for their role. Records reviewed in staff files showed documentation of completed orientation checklists and competencies.</p> <p>Continuing education is planned on an ongoing basis. A comprehensive training plan outlines the requirements for all levels of staff within the organisation. Care staff have difficulty accessing New Zealand Qualification Authority education programmes; however, access to training on relevant topics is made available and information about these are in the training plan. There are enough trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed indicated that not all staff have completed their training and/or professional development requirements. This has been raised for corrective action, as has the need for all staff to have a current annual performance appraisal.</p>
<p>Standard 1.2.8:</p>	<p>PA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe</p>

<p>Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>Moderate</p>	<p>service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of patients. An afterhours on call roster that includes on site access to a general practitioner, is in place, with staff reporting that good access to advice is available when needed.</p> <p>Care staff reported there is adequate staff available to complete the work allocated to them. Patients interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced by a casual staff person in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 registered nurse coverage in the hospital. Registered nurses and GPs all have level seven first response training in order to maintain the emergency unit. A registered nurse, an enrolled nurse and a healthcare assistant is rostered on morning shifts, a registered nurse and two healthcare assistants are rostered on afternoon shifts and a registered nurse and a healthcare assistant on the night shift. A registered medical practitioner (locum) and/or a GP is on site, or in the immediate vicinity, at all times and the locum/GP on duty covers inpatient and emergency services.</p> <p>An interim solution is assisting with the current lack of midwifery support, and discussions are underway to have this addressed. A corrective action has been raised as this is not yet in place. Also, at the time of audit there was no clinical manager as required by the contract and this has been included in the corrective action for this standard.</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>There is a medication policy which is current and identifies all aspects of medicine management. A safe system for medicine management was observed on the days of the audit. The staff observed have completed competencies as have all staff who administer medications. Certificates and training was verified. This was an area identified in the previous audit which has been addressed.</p> <p>The service has a contract with a pharmacy in Gisborne and blister packs are made up for the long term care residents and delivered to the facility.</p> <p>Sixteen-day medication records were reviewed for the long term care patients and eight-day national medication records were used for the medical and maternity patients admitted to the respective services. There are no standing orders as a doctor is available daily. Verification of all medication administrators and prescribers' signatures was available. The midwife interviewed can prescribe within the midwifery scope of practice.</p> <p>The medication trolley was stored in the main office when not in use. The records of temperatures for the medicine fridge were reviewed and were within the recommended range.</p> <p>All emergency drugs are checked along with all equipment and resources for the acute admission room. A minimal amount of mild analgesia is available in the maternity unit.</p> <p>Good prescribing practices were noted and included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro nata (PRN) medicines were met. For the long-term residential care patients there was evidence of the GP/locum doctor reviewing the medication three</p>

		<p>monthly for each patient and this was recorded on the hardcopy medication records reviewed.</p> <p>There were no patients self-administering medications at the time of the audit. Processes are in place to ensure this is managed in a safe manner should this be required.</p> <p>Medication errors are reported to the registered nurse and an incident form is completed and given to the hospital manager. There is a process for analysis of any medication errors as part of the incident management system.</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>	PA Low	<p>The cook was interviewed and had worked at this facility for nineteen years. The cook works Monday to Friday and is supported by kitchen staff who work in the afternoon and over the teatime. Monday is designated for the cook to complete ordering of food, to complete food service audits and other administrative responsibilities. Cover is provided for the cook by an experienced kitchen hand. The seasonal four weekly menu plans were discussed and sighted. The menu plans had not been reviewed for three years. Any changes made by staff were documented on the plans reviewed. The food control plan is work in progress with an audit planned for this month. Special events are catered for on a regular basis.</p> <p>The cook is responsible for all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal of all food stuffs. All requirements are effectively met. The kitchen was clean and tidy and maintained to a high standard. Any special diets are catered for. A copy of the nutritional assessment completed for all patients on admission to the service is provided to the cook and a copy is retained in the records reviewed. Cleaning schedules are completed and requirements are displayed in the kitchen. Temperature monitoring of all fridges and freezers occurs and the records were sighted. Temperature checks of all foods delivered and prepared for patients are maintained. The doctor's meals are also catered for when working at the hospital and when on call.</p> <p>Patients interviewed in both the inpatient service and the women/wahine who have accessed the maternity service spoke highly of the food provided. Patients requiring assistance with their meals were assisted as required.</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>	FA	<p>Observations, interviews and documentation evidenced patient care was provided that was consistent with meeting the needs and identified goals of the patients in each area of service provision reviewed. The GP was not available on the days of the audit for interview; however, the clinical nurse adviser was available. The medical records reviewed evidenced that medical input is sought in a timely manner and routine reviews were undertaken. If and when the patient's needs changed the doctor was called and care was provided as outlined in the medical/nursing records reviewed. The service has a range of equipment and resources available suited to the level of care provided and in accordance with patients' individual needs. The CNA is currently providing education on advance care planning to all staff and documentation was being printed to be used by the service provider when required.</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>PA Low</p>	<p>The activities for the long term care patients are provided by the ward staff. There were no social assessments or plans sighted in the sample of patients' records reviewed. There is a documented programme which is altered according to what activity is provided at the time. There is no evidence of a diversional therapist having oversight of the activities programme. No attendance records are maintained on a regular basis for the long term care patients. Entertainers were visible on the first day of the audit and patients interviewed enjoyed the activity provided. There is a lounge available and an outside veranda to use for the activities. Activities in the community are encouraged by the staff. Hospital cars are used with designated drivers being available.</p> <p>Parenting skills are promoted by the midwife and staff from the ward who cover postnatally in the maternity unit at every opportunity. Assistance and support is provided with breastfeeding as needed. One of the locum midwives is also a lactation consultant s is able to provide additional support if required.</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>Patient care is evaluated on each shift and is documented in the progress records. If any changes occur with any patient the registered nurse/registered midwife is to be contacted. For the long term care patients care evaluations occur every six months or earlier if and when required. The six monthly interRAI re-assessment assessments are completed by the registered nurse (one registered nurse is interRAI competent and one is in training). Where progress is different than expected the service responds by initiating changes to the care plan. Short term care plans are being used as required and these were sighted. Progress is evaluated as clinically indicated and according to the degree of risk recorded during the assessment process. Any triggers or outcomes are considered after the re-assessment interRAI is completed. The service has not yet implemented the early warning scores (EWS) for the medical inpatients. The CNA discussed this at interview and is currently awaiting approval from the clinical approval group for the EWS records to be implemented. The medical staff would be contacted if any changes occurred. Patients interviewed stated they were consulted and involved in evaluation of progress and any resulting changes.</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,</p>	<p>FA</p>	<p>All chemicals/hazardous substances sighted were labelled to enable easy identification of their ingredients and use. These were stored in a locked cupboard. Material safety data sheets were also available. The chemicals previously stored in an external shed that was not locked at the last audit are no longer stored on site. This shed now contains bio-waste and was locked on the day of audit. Records viewed confirmed a person has been suitably trained as an approved handler of chemicals and hazardous substances. The evidence described verified that the corrective actions raised at the last audit against this standard have been addressed.</p>

infectious or hazardous substances, generated during service delivery.		
<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	The building has a current warrant of fitness with an expiry date of 30 June 2019.
<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	Evidence of a fire evacuation trial having occurred, and records forwarded to the fire service in November 2018, were viewed. The next is scheduled for May 2019. In addition, an approved fire evacuation plan obtained from the fire service in February 2019 was sighted. The issues raised for corrective action at the last audit have since been addressed.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p>	PA Low	<p>An overview of infection surveillance processes appropriate to the range of services provided at Ngati Porou Hauora is included in the infection prevention and control manual. Although the manual describes the roles and responsibilities of an infection control coordinator and the infection control committee, there is not currently a designated infection control coordinator and there were no infection control meeting minutes for 2018. A staff person and the quality coordinator confirmed no meetings had occurred during 2018, although one had taken place in February 2019. Minutes from the February meeting list infection prevention and control committee members. Recommendations in a quality management review note the need to train a registered nurse for the infection control coordinator role and for infection control committee meetings to become regular again.</p> <p>Staff reported low rates of infections in the facility; however, as no infection related data had been collated, there was no evidence of any analysis of it, nor of any possible causative factors identified or applicable actions</p>

control programme.		<p>undertaken. In the absence of infection surveillance processes, a corrective action has been raised.</p> <p>Surveillance policy and procedures are documented to guide staff. Any new infections are discussed at staff handover to ensure early intervention occurs. Staff interviewed stated they report infections; however, it could not be established who was responsible for this role. Reported infections are not currently being collated and analysed monthly to identify any trends or possible causative factors for required actions to be put in place. There have been no infection outbreaks since the previous audit. The doctors are available to review laboratory results.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The organisation's policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The registered nurse interviewed is the restraint coordinator and understood the responsibilities of this role.</p> <p>On the day of audit there was one restraint in use and one enabler. Restraint is used as a last resort when all alternatives have been explored. The records reviewed supported this process and staff interviewed fully comprehended the processes in place (refer to 1.2.3.5). Education is provided to staff annually on restraint minimisation and safe practice.</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 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	<p>PA</p> <p>Moderate</p>	<p>The quality management plan notes that quality and risk activities are to be discussed at three key sets of meetings: the clinical governance group, the clinical advisory group and the health and safety team. Meeting minutes reviewed showed that there had not been any such meetings at which quality and risk was discussed since 2017. There was also evidence that there are some ad hoc reporting processes with some quality activities now the responsibility of the hospital services manager, while others are undertaken by the quality coordinator. This has contributed to some gaps in the reporting of quality related activities. Infection prevention and control has its own meetings; however, as identified for corrective action in 3.5.7, this has not been occurring for more than a year.</p>	<p>Not all aspects of service delivery are being integrated into the quality and risk management system. For example:</p> <ul style="list-style-type: none"> <li>• There was no evidence to show that restraint minimisation and safe practice is reported at the clinical governance, or clinical advisory levels of the quality system</li> <li>• Infection control reporting is no longer occurring</li> <li>• Patient satisfaction surveys have not been</li> </ul>	<p>All aspects of service delivery, including restraint minimisation, infection control, associated internal audit outcomes, patient surveys, health and safety and aspects of service delivery requiring quality improvement are integrated into the organisational quality and risk management system.</p> <p>90 days</p>

		<p>There was an absence of evidence to confirm that some key components of service delivery have been reviewed using the quality and risk management system over the past twelve to eighteen months. These included an absence of internal audit outcomes from a range of aspects of service delivery, a lack of reporting on restraint minimisation and infection control, no patient/family satisfaction survey results available and no evidence of health and safety reviews. The need for the quality and risk management system, especially those aspects related to service delivery, to be reinstated as per the documented plan has been raised for corrective action.</p>	<p>completed</p> <ul style="list-style-type: none"> <li>Internal audit results of aspects of service delivery were not available</li> <li>Health and safety internal audits are being completed; however, there is no longer any overall review or coordination of health and safety occurring</li> <li>Quality and risk management and quality improvement issues overall are being reported through a variety of channels in an almost ad hoc fashion, rather than in a coordinated manner</li> </ul>	
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of</p>	<p>PA Moderate</p>	<p>A hazard register is in place and is being regularly reviewed. Risks are being identified by the quality coordinator as part of the review and analysis of accidents and incidents or complaints for example. These issues-based risks are being entered into a register, which includes follow-up actions for ongoing review to ensure there is no recurrence.</p> <p>There was no organisational risk register available that includes the identification, categorisation or mitigation strategies for potential and ongoing risks associated the service. With no risk register for risks not</p>	<p>There is no overall organisational risk management plan/register to enable ongoing and potential risks to be monitored, analysed and evaluated for quality improvement purposes.</p>	<p>A risk register is implemented to enable the identification, monitoring, analysis, evaluation and review of potential and ongoing organisational risks that are reviewed at a frequency determined by the severity of the risk and the probability of change in the status of the risk.</p>

the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.		associated with events/issues that have already occurred, there is no ongoing monitoring of unidentified organisational risks.		90 days
Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	Health professionals are responsible for renewing their own registrations and for achieving their own professional development requirements. Organisational records pertaining to professional registrations and scope of practice lack consistency and the system is not coordinated. The managers cannot be certain that the health professionals involved in service delivery have a current registration and scope of practice.	There is no process/system in place for the organisation to verify that all associated health professionals have a current practising certificate.	A system/process that enables the organisation to confirm professional registrations and scopes of practice are current is required.  180 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	Staff are responsible for seeking, completing and attending staff training opportunities and for meeting any individual professional body requirements. There are multiple training opportunities that are made available for staff, especially of an e-learning nature. The quality and training coordinator has developed a comprehensive training plan that determines what training is required for each category of worker, describes how to access each training topic and includes hyperlinks to e-learning packages. Optional special interest topics have been included. Staff have been asked to complete a form detailing their professional development and training; however, organisational records of staff training remain	There is not currently a system that enables managers to easily know what training a staff person has or has not completed.  Annual performance appraisals were overdue in five of six staff files reviewed and senior staff confirmed these are now out of date for most staff.	An accurate recording system of staff education uptake is required to ensure the patients receive safe and effective services.  All staff are required to have undertaken a performance appraisal within the preceding 12 months.  90 days

		<p>incomplete and do not demonstrate that professional or contractual requirements have been met.</p> <p>Staff training is a topic included in the annual appraisal process. However, records available demonstrated that staff and management annual performance appraisals are overdue. This was confirmed by staff and managers interviewed.</p>		
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>A midwife is employed by the organisation and during interview informed she is now managing a caseload of around 50 mothers and babies at varying stages of pregnancy and post-partum care. Many of these are in isolated rural areas and access can be a challenge at times. It was reported that this is an increase on previous numbers attended. Although Tairāwhiti DHB is responding in the interim to the need for this person to have some relief, by providing access to other midwives, this is not a long-term solution. The management team informed that they are currently in discussion with three midwives who may be able to assist in the future; however, at the time of audit this was not formalised, and the board and management had still to decide in what way they would be used, for example, casual, part time or contract.</p> <p>A registered nurse was working as a team leader of clinical services until 2018, when an agreement was reached that the hospital services manager (non-clinical) would manage the hospital with assistance from a clinical nurse leader from Tairāwhiti District Health who visits the unit most weeks and oversees the clinical care. This does not meet the requirements of</p>	<p>The midwife who is employed by the organisation has significantly increased her caseload. While this is an asset to the service, it has the potential to negatively impact on patient safety and wellbeing.</p> <p>There is not currently a designated clinical manager responsible for hospital level aged care services, as required by the ARRC Agreement.</p>	<p>A clinical manager is appointed to meet contractual requirements. Maternity service staffing levels are improved to ensure the safety of services delivered.</p> <p>90 days</p>

		the Aged Related Residential Care Agreement clause D17.4ba (i) and (ii), which requires the hospital service to have a full-time position clinical manager to work with a manager who is non-clinical, and this has been included in the corrective action for this standard.		
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	<p>The cook interviewed works in line with recognised nutritional guidelines for older people. The menu plans sighted were four weekly and seasonal. All ingredients required for each meal were documented for the cook or kitchen hands to follow. The menu plans were flexible and any changes were documented. The menu plans had not been reviewed for three years, though reported to management. All other individual food, fluids and nutritional needs for patients are met as discussed with the cook at the time of audit.</p>	<p>The nutritional needs of patients are effectively met. All special diets are catered for. The service is covered by an experienced cook and kitchen staff. The four weekly summer /winter menu plans have not been reviewed by a registered dietitian for three years.</p>	<p>Ensure the menu plans for the service have been reviewed by a registered dietitian in the required timeframe as per the service contract with the DHB.</p> <p>180 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>The staff provide the activities on a daily basis. The patients interviewed enjoyed the interaction with the staff and the activities provided at the time of the audit. The documented programme was basic and flexible. There was no involvement of a diversional therapist. There were no social assessments or activities plans/goals completed for each patient in the records reviewed or evidence of attendance and participation.</p>	<p>A basic activities programme is developed and implemented which is flexible and incorporates some activities of interest to the current patients. However, there is no evidence of a social assessment being completed when a new patient is admitted to ensure activities are planned to develop and maintain skills, resources and interests that are</p>	<p>A social assessment is performed on admission to ensure the interests, background and hobbies of the individual patient is obtained and considered when developing the activities programme and the individual plan for each patient to meet their recreational needs. The programme requires input from a diversional or occupational</p>

			meaningful to the individual patient. No attendance records are maintained. No input from a diversional therapist was able to be evidenced.	therapist. Attendance/participation, while not compulsory, is to be recorded as per the service contract with the DHB.  180 days
Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.	PA Low	The surveillance policy is in place, but the current implementation was not able to be evidenced. Staff interviewed understood what type of surveillance was required but no records of this were available at the time of the audit.	The staff interviewed were aware of what types of infections are to be reported for surveillance purposes. It was not able to be established as to who was responsible for this role and/or the frequency of with which this surveillance was to be undertaken.	The type and frequency of surveillance required is determined for the size and complexity of the organisation and a staff member has responsibility for the documented surveillance programme.  180 days
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	PA Low	Staff reported that infection related risks are minimal as infection rates are very low with most infections occurring in the outpatient service and managed by the GP service. However, other than an infection prevention and control committee meeting in February 2019, the oversight of infection prevention and control processes has not been occurring for more than twelve months. There is also no suitably trained or qualified infection control coordinator. As infection related data has not been collated, there has been no subsequent analysis able to occur and therefore no ability to identify recommendations that might assist in reducing the number or severity of infections that do	There is no infection prevention and control coordinator. The incidence of infections has not been recorded or reviewed to enable surveillance processes to be undertaken for infection prevention and control purposes.  The incidence of infections is not being recorded or reviewed to enable surveillance processes to	A suitably trained and qualified infection control coordinator is appointed and surveillance of the incidence of infections is undertaken in accordance with the directions for these processes as described within the organisation's infection prevention and control manual.  Ensure the surveillance reflects all infections

		<p>occur.</p> <p>The infection prevention and control processes are understood by staff; however, with decreased numbers of patients presently there has been a lapse in recording infections and the types of infections especially required for the surveillance programme in relation to long term care patients so that any trends or causative factors can be addressed.</p>	<p>be undertaken for infection prevention and control purposes.</p>	<p>reported and that feedback can be given to staff to act on or to prevent infections in a timely manner.</p> <p>180 days</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.