Wharekaka Trust Board Incorporated - Wharekaka Rest Home

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:	Wharekaka Trust Board Incorporated
Premises audited:	Wharekaka Rest Home
Services audited:	Hospital services - Medical services; Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 April 2019 End date: 18 April 2019

Proposed changes to current services (if any): Geriatric Hospital Services to be included in scope as per previous partial provisional audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 18

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

Wharekaka Rest Home provides rest home and geriatric hospital level care for up to 20 residents. The service is operated by Wharekaka Trust Board Incorporated and managed by an interim facility manager who is a registered nurse. The service was managed by a senior registered nurse for two weeks prior to the facility manager being contracted following the resignation of the previous general manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the Wairarapa District Health Board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, and a general practitioner.

This audit has resulted in areas requiring improvement relating to complaints, hazards, corrective action documentation, restraint management and medication competency documentation.

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

Residents and their families are provided with a copy of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights as part of the information portfolio given on a resident's admission. Services are provided that support personal privacy, independence, individuality and dignity, and staff were observed interacting with residents in a respectful manner. An interpreter service is available on request but has not been required.

Policies are in place to ensure residents are free from discrimination, or abuse/neglect. Residents and family interviewed reported that they are always treated with respect. During the audit, staff were observed offering choices and acknowledging individual rights and beliefs.

The service has links with a range of specialist healthcare providers to support best practice and meet residents' needs when required.

Completed adverse event reports showed that open disclosure is occurring. Staff provide residents and families with the information they need to make informed choices and give consent.

Complaints are resolved promptly and 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 low risk.

Strategy, business and quality and risk management plans include the goals, values and mission statement of the not for profit trust. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person has recently been contracted to manage 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 support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. Regular individual performance reviews are completed. 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.		Some standards applicable to this service partially attained and of low risk.

Residents' needs are assessed on admission and used to provide individualised care plans. Files reviewed demonstrated that the care provided and needs of the residents are reviewed and evaluated on a regular basis, with input from the residents and their families.

Residents are referred to other health services as required after consultation with the doctor, registered nurse (RN), resident and family or support person.

Medications are prescribed appropriately, and accurate records kept. Administration of medications was safe and consistent with good practice.

Planned activities with a variety of entertainers, outings and group activities maintain residents' links with the community.

The kitchen was clean and well organised. Individual food preferences and specific dietary needs were catered for. The menu is reviewed by a qualified dietician every two years and meets the guidelines for nutrition for the older person.

The general practitioner, who was interviewed during the audit, reported that the care the staff deliver is of a high standard, and follows medical treatment recommended.

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.

Wharekaka Rest Home meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. 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. Security is maintained.

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

The organisation has implemented policies and procedures that support the minimisation of restraint. Two enablers and two restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process occurs. Use of

enablers is voluntary for the safety of residents in response to individual requests. Wharekaka Rest Home staff demonstrated 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.		Standards applicable to this service fully attained.

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

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	46	0	4	0	0	0
Criteria	0	96	0	5	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Wharekaka Rest Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. Training was held in October 2018.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. This includes delivery of treatment, photos, and transportation for outings. A separate consent was obtained for flu vaccination. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Wharekaka Rest Home have their own advocate who visits once a week to connect with residents, and helps write letters, fill in complaint forms, communicates with management and runs the monthly meetings for residents. Residents were familiar with how to contact the service and shared that they felt the advocate was effective in their role.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	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 has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The Wharekaka Rest Home complaint policy, flowchart 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 how to do so. The complaints register reviewed showed that three complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required, however they described actions taken in response to concerns which are not documented within the complaints management system. These opportunities for improvement are not included in the complaints register therefore cannot be investigated, monitored, analysed or trended. There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	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, from discussion with staff and by contact with the advocate who visits Wharekaka Rest Home each week. The Code is displayed in the dining room and inside the front door areas together with information on advocacy services and how to make a complaint and feedback forms.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room, staff were observed closing curtains and doors when providing cares. Residents are encouraged to maintain their independence by maintaining contact with friends and organisations they belonged to prior to admission to the rest home, and arranging their own visits to the doctor if they were able. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented during admission and incorporated into their care plan. Staff received training from Aged Concern on abuse and neglect in December 2018. Care staff interviewed could explain what actions they would take if they saw any signs or had concerns. Residents interviewed shared that they felt safe at Wharekaka Rest Home.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	There were no residents who identifies as Māori at the time of the audit. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Staff attended cultural safety training in April 2019. A record is kept of when Kaumātua visit.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents verified that they were consulted on their individual, ethnic, cultural, spiritual values, and beliefs on admission, and on an ongoing basis. All lifestyle plans reviewed reflected the personal preferences and individual requirements of the residents, with goals and interventions documented to ensure these were met. Monthly church services are held for different denominations.
Standard 1.1.7: Discrimination Consumers are free from any	FA	Residents and family interviewed stated that they felt safe and were free from any type of discrimination or exploitation. Staff demonstrated a clear understanding of what would constitute

discrimination, coercion, harassment, sexual, financial, or other exploitation.		inappropriate behaviour and the processes they would follow should they suspect this was occurring. All registered nurses have completed professional boundaries through the Nursing Council of New Zealand. Policies and procedures contain a list of “house rules” which inform the staff of appropriate behaviour. These are also displayed in the staffroom and nurses’ station.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Wharekaka Rest Home has a professional network with a range of external specialist services and allied health professionals. These include wound care specialists, mental health services for the elderly, physiotherapists and dieticians. These are a source of additional knowledge and expertise to supplement their own skilled staff. The RN reported that they receive management support for external education and have attended study days for wound care. They also use online research through healthLearn. A palliative care workshop was advertised in the staffroom. The general practitioner interviewed confirmed that the service sought prompt and appropriate medical intervention and were responsive to medical requests.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Each resident’s file reviewed contained written documentation of family contacts, and confirmation of contact in the progress notes. Adverse event forms demonstrated open disclosure and effective communication with residents and their family/whānau. Family members stated that they were informed in a timely manner of any changes in their relative’s health status. Interpreter services are available through the District Health Board. Although the service has not been used, contact details were available. The RN also stated that the local marae were willing to interpret for Māori residents if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Wharekaka Rest Home is governed by a not for profit trust. The strategic plan 2018 - 2023 and 2018 business plan, which are reviewed annually, outline the mission, values, and goals of the organisation. The documents described annual and longer term objectives and included known risks and mitigation strategies. A sample of board minutes which incorporate monthly reports to the board of trustees showed adequate information to monitor performance is reported including clinical management, projects, compliance, health and safety, quality benchmarking, occupancy, financial performance, emerging risks and issues. The service is managed by an interim facility manager who is a registered nurse with relevant qualifications and experience who has been in the role for a month only. Responsibilities and

		accountabilities are defined in a job description and individual employment agreement. The interim facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through professional memberships and work experience. Wharekaka Rest Home holds contracts with the Wairarapa District Health Board (DHB) for age related residential care provided in rest home and hospital services, including day care. Five people were receiving hospital level services and 13 residents were receiving rest home services on the day of audit. The service is contracted to provide respite, health recovery and palliative care services, however no residents were receiving these services on the day of audit.
Standard 1.2.2: Service Management 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.	FA	When the facility manager is absent, the senior registered nurse carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the general manager who has a current annual practising certificate, is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, a regular resident satisfaction survey, resident involvement in decision making, monitoring of outcomes, clinical incidents including infections, falls, medication errors and pressure injuries. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the clinical committee, registered nurses' meetings and staff meetings. Staff reported their involvement in quality and risk management activities through incident reporting, audit activities, training and meeting attendance. Resident and family satisfaction surveys are completed annually. The most recent survey in August 2018 showed residents and family are mostly very satisfied with the services provided. Area for improvements were identified and actions taken by the previous general manager in relation to a negative comment regarding the evening meal, maintenance delays, communication with management and toilet access. Policies reviewed cover 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, were current and are reviewed by an external expert. The

		document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The system is managed at Wharekaka Rest Home by the facility manager. The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The facility manager and the health and safety representative are familiar with the Health and Safety at Work Act (2015), however there is no up to date relevant hazard register. Relevant corrective actions have not been consistently developed and implemented to address any shortfalls.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Wharekaka Rest Home staff document adverse, near miss events and minor complaints on an accident/incident form and the information is entered into a recently introduced electronic benchmarking system by the senior registered nurse. The facility manager is alerted every day to incidents and reported immediate actions are taken as required. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, and actions followed-up in a timely manner. One example of this was the analysis and trending of falls data and implementation of roster changes in response to issues identified by the interim facility manager. Adverse event data is collated, analysed and reported to residents, staff and the trust board. The interim facility manager described essential notification reporting requirements, including for pressure injuries, and examples reported by the previous general manager were sighted. The interim facility manager advised there have been several notifications of significant events made to the Ministry of Health since the previous audit including the change in manager, a norovirus outbreak, a power outage and the issue with e-coli in the town water supply.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources management policies and processes followed at Wharekaka Rest Home 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. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period. Continuing education is planned on an annual basis, including mandatory training requirements.

		Some topics are only required biannually, such as first aid re-certification. 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. A staff member is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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 (24/7). Wharekaka Rest Home adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of several weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All RNs are required to have a current first aid certificate which ensures at least one staff member on duty has a current first aid certificate as there is 24/7 RN coverage in the hospital.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All components of the residents' records reviewed included the residents' unique identifier. Files were well organised and fully integrated, including information such as wound care plans, allied health visits, laboratory results, and medical files. All records were kept in the nurses' station in a locked cupboard, where the door was shut if no staff were present. Archived material was available and stored securely in a filing cabinet. Detailed progress notes were maintained and updated each shift. Staff signatures and designations were sighted. 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	FA	Residents enter Wharekaka Rest Home after being assessed by the local Needs Assessment and Service Coordination Service known as FOCUS and having had the level of care required determined. Prospective families are encouraged to visit the facility and receive written information about the service in an Information Portfolio. This includes information on the Code, advocacy service, how to make a compliment/complaint, informed choice and consent, service fee, family information, resident information and a welcome letter. Family expressed during an

identified.		interview that this information was helpful and the admission process was streamlined and maintained their privacy by taking place in a family room. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance 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, as well as a check list in resident's file as to what paperwork to send and who to contact. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information is provided for the ongoing management of the resident in writing and via telephone. All referrals are documented in the progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	Medications are supplied using the robotics medication roll system from a contracted pharmacy. These are reconciled against the medication chart by the RN on duty when they arrive. They are then entered into the electronic system as a record of delivery. Each of the ten medication charts reviewed contained a current photograph and their allergy status was recorded. All medications were appropriately charted. Discontinued medications were signed by the general practitioner and pro re nata medications had indications for use. A medication round observed was performed in a safe manner. The RN wore an apron indicating he was unavailable. Staff had a clear understanding of their responsibility around adverse reactions, and where to obtain information on the medications. All medications are stored in a locked cupboard in a methodical way and evidence of stock rotation was observed. Controlled drugs were locked in a metal cupboard and administered by two staff. The controlled drug register had accurate balances and evidence of weekly and six-monthly stock balances. Temperature of the medication fridge are recorded on a daily basis and were within the recommended range and all eye drops are dated and within the use by period. At the time of audit, one resident was self-administering their medications in line with the policies and procedures for this process. There is a specimen signature sheet in each resident's file current at time of audit. There was no staff medication competency register able to be sighted during the audit.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Food service is provided on site by a cook and kitchen team who have completed training in safe food handling. Certificates were sighted. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The current food control plan was verified by South Wairarapa District Council on 25 July 2018 and is on display by the main entrance. Residents complete a nutritional profile on admission which details any allergies, likes/dislikes, special nutritional needs, and if modified cutlery is required. This information is sent to the kitchen where it is posted on the wall and is checked when serving meals. The menu is divided into summer and winter time frames and within that is a five-week rotating menu providing a range of nutritious meals. The menu was reviewed by a qualified dietician as being in line with recognised nutritional guidelines for older people on 7 August 2018. On inspection, the kitchen was clean, tidy and well maintained. Temperatures of both food and fridge/freezers were recorded at recommended times and were within the expected limits. Food stored in the fridge was covered and dated with meat stored below other food. Dry goods in the pantry were stored appropriately with dated containers and evidence of stock rotation seen. Special diets are catered for and special crockery and cutlery were available. The meal time observed was calm, unhurried and residents stated they enjoy the variety of meal. Those requiring assistance were given it in a respectful and dignified manner.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, FOCUS 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 FOCUS is made and a new placement found, in consultation with the resident and family. The (registered nurse) RN gave an example of a resident who was transferred to a secure facility unit following this process.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as, mobility assessment, falls risk, skin integrity and a nutritional profile, as a means to identify any deficits and to inform care planning. Further assessments were made if a need was indicated. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of three trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The care 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. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The RN is available to give support and guidance to care assistants which was observed at handover. Before staff finish their shift, they report back to the RN any relevant information, to be handed on to the next shift. During interviews with residents they expressed that they were happy with how their needs were meet. The GP interviewed reported that medical input is requested in a timely manner, medical orders were followed, and that the residents receive a high standard of care.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme is provided by a coordinator who works four days a week and has held the position for three years. The coordinator holds an international qualification and is in the process of cross crediting this to the New Zealand standard. A caregiver runs the programme one day and at the weekend entertainers come in and movies are screened. A weekly programme is planned, and a calendar is distributed to all residents and posted on the notice board. A varied range of activities are held including, Pilates, Tai chi, church services, quizzes and local entertainment. Wharekaka Rest Home also has an auxiliary group that come and cater special afternoon teas and are involved in fundraising. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. A system called 'Golden Carers' tracks activities and attendance and provides ideas to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly as part of the formal care plan review. Residents' meetings give residents opportunity to have input into the programme and provide feedback, which was verified by meeting minutes. Residents interviewed expressed satisfaction with the programme and felt free to join in with activities of their choice.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care plans are reviewed six monthly in line with interRAI reassessments, or as a resident's needs change. Where progress is different from expected outcomes adjustments are made to the interventions, signed and dated. Residents are evaluated every shift with staff reporting to the RN changes from the usual patterns of behaviour. The RN reported that short-term care plans are used for such things as infections or wounds and were assessed weekly or sooner if medically required. When necessary they are transferred to the long-term care plan if not resolved within six weeks. Residents and family spoke of being involved in the evaluation process.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	If the need for other services is identified the general practitioner or RN will complete a referral to seek specialist provider assistance. During the interview with the RN examples were discussed and forms reviewed for such services as the dietician and wound specialist nurse. Family/whānau are kept informed during the process as was verified by the family contact page. Residents are free to choose the house doctor or maintain care under their own GP. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Wharekaka Rest Home staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment such as aprons, gloves, masks and face shields and staff were observed using this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for	FA	Wharekaka Rest Home has a current building warrant of fitness (expiry date 30 June 2019) which is publicly displayed in the main reception area. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed,

their purpose.		interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. Expansive external areas are safely maintained and are appropriate to the resident group and setting, with flat easy access to the surrounding streets which lead to the centre of town. Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned. Residents interviewed were happy with the environment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout Wharekaka Rest Home. This includes shared facilities and ensuites. Appropriately secured and approved handrails are provided in the toilet and shower areas, and other equipment and accessories are available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided at Wharekaka Rest Home 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. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Wharekaka Rest Home has large communal areas available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access within the spaces and out into the parklike grounds, for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services	FA	Laundry is undertaken on site at Wharekaka Rest Home in a dedicated laundry and by family members if requested. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents and family interviewed reported

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		the laundry is managed well and their clothes are returned in a timely manner. There is a small designated cleaning team who have received appropriate training as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through family and resident feedback, management and staff informal inspection and the internal audit programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Wharekaka Rest Home have policies and guidelines for emergency planning, preparation and response which 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. There was an emergency situation with the town water supply on the day of audit which was being responded to appropriately in conjunction with the local council. The current fire evacuation plan was approved by the New Zealand Fire Service on the 19 December 2016. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 26 October 2018. The orientation programme includes fire and security training. Staff interviewed confirmed their awareness of the emergency procedures. Adequate 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 18 residents and staff. A water storage bladder provided by the council was located on the front garden during the audit. The water provided by the council to refill the bladder was specifically treated to combat the E-coli detected in the town water supply. Wharekaka Rest Home also has water storage round the complex, and a generator is hired in for planned and unplanned power outages. Emergency lighting is regularly tested. Call bells throughput the facility 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. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the local Police are called if there are any security concerns.
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	All Wharekaka Rest Home residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and one corner bedroom has doors that open onto the outside garden areas. Heating is provided by heat pumps and radiators

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management 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.	FA	The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme from an infection control advisory service is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually and were due for review the month of the audit. The facility manager is the designated IPC coordinator assisted by a team including the cook, one RN and one caregiver. Infection control matters, including surveillance results, are reported monthly at the quality/risk committee meeting. Input from the infection control coordinator for the DHB is utilised as required. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. At the time of the audit, the community was involved in a contaminated water supply event. Appropriate signage was displayed and measures were in place to provide water from other sources. Management of infection prevention and control are appropriate for the size and scope of the facility.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role. Additional support and information is accessed from the infection control coordinator at the DHB, the community laboratory, and the GP as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. An outbreak kit was sighted and was appropriate for use.
Standard 3.3: Policies and procedures Documented policies and procedures	FA	Documented policies and procedures are in place to minimise and manage infections in the facility. They reflected current best practice and meet standard requirements.

for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		Care delivery, cleaning, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the IPC coordinator from the DHB, with a session booked next month. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred in March 2019 during a Norovirus outbreak. All appropriate procedures were followed and follow up with the Ministry of Health was signed off on 15 April 2019. Education is provided by the coordinator from the DHB with a session booked for May 2019.
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.	FA	Surveillance is appropriate to that recommended for long term care facilities of this size and scope. All infections are entered onto an infection control form tabling type of infection, when the GP was notified, what antibiotics were charted and when the issue was resolved. A log is kept of infections in each resident's file. Infections monitored and analysed on a monthly basis include eye, ear/nose/throat, urinary tract, respiratory, gastro intestinal tract and any multi resistant organisms. This information was then graphed, analysed and compared to other data in the same month and same time of year. Results were available for staff to view. Recommendations are discussed and implemented as appropriate at staff meetings and staff shift handover.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated an understanding of Wharekaka Rest Home's policies, procedures and practice and her role and responsibilities. On the day of audit, two residents were using restraints. Two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed

		for the use of enablers as is used for restraints. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the clinical committee and staff meeting minutes, files reviewed, and from interview with staff.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval group, made up of the restraint coordinator, general practitioner or nurse practitioner, and clinical nurse manager, are responsible for the approval of the use of individual restraints and the restraint processes. It was evident from review of residents' files and interviews with the coordinator that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/whanau or EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of the two restraints at Wharekaka Rest Home were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whanau or EPOA. The restraint coordinator interviewed described the documented process. Families confirmed their involvement. The general practitioner or nurse practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of the two Wharekaka Rest Home residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	At Wharekaka Rest Home the use of restraints is actively minimised and the restraint coordinator described referral to the local DHB allied health professionals for expert advice, and how alternatives to restraints are discussed with staff and family members such as the use of sensor mats, and low beds. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.

		A restraint register is maintained, updated every month and reviewed at each clinical and staff meeting. The register was reviewed and contained all residents currently using a restraint as well as all resident using enablers and sufficient information to provide an auditable record. Staff have received training in Wharekaka Rest Home's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the medical review meetings. Wharekaka Rest Home families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	PA Low	A three or six monthly review of individual restraint use as part of the medical review is reported to the clinical committee RN meeting and staff meetings. Minutes of meetings reviewed confirmed this includes the amount and type of restraint and enabler use in Wharekaka Rest Home, whether all alternatives to restraint or enablers have been considered, and the effectiveness of the restraint in use. The competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families are gathered within the education programme and in residents' files respectively. Any changes to policies, guidelines, education and processes are implemented if indicated. A six-monthly review of all restraint use which includes all the requirements of this Standard is not undertaken.

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)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	The Wharekaka Rest Home concerns/complaints policy recognises that both concerns and complaints provide valuable information for reviewing service provision. Staff described that they know to escalate any complaints and they are aware of their responsibilities to follow the requirements of the Code, however they described resident concerns as being addressed at the time and documented within the residents’ files and at handover. These concerns do not get entered into the complaints register and are therefore not linked to the quality and risk management system.	There is no up to date complaints register that includes all concerns/complaints dates and actions taken.	Ensure all resident and family concerns are entered into the complaints register and therefore linked into the quality and risk management system. 90 days

Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	Incident reporting, complaints management, resident feedback, satisfaction surveys, staff training, infection control, health and safety, internal audit and restraint and enable management are explicitly linked to the quality and risk system within the quality improvement programme. There was regular risk management analysis reported to the trust board by the previous general manager and hazards have been identified and eliminated or minimised as they have occurred. Staff were able to identify some but not all hazards they are exposed to. There is no documented hazard register which lists the hazards staff and residents may encounter and no mitigating actions, review or responsibilities expected within a current hazard register.	Health and safety actual and potential risks are inconsistently identified, documented and managed and there is no current up to date hazard register.	Document a relevant hazard register in conjunction with staff and residents that reflects the current hazards, provides relevant safety information to staff and residents, is reviewed regularly and is based on current best practice. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	The interim facility manager and staff described examples of corrective actions being developed and implemented in response to identification of non-compliance following internal audit however these were not documented, or reviewed for effectiveness so opportunity to monitor, trend and analyse areas of non-compliance from a quality perspective have been missed.	Corrective actions are not consistently documented in response to identified areas of non-compliance.	Create corrective action plans in response to all areas requiring improvement to provide a link to the quality and risk system. 90 days

Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	Staff were observed to deliver medication in a safe and competent manner and had understanding of prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. However, there was no documentation to provide proof of current competency.	There is evidence of a process for staff responsible for medication management to follow to complete and maintain annual medication competency. There was no evidence able to be sighted that indicates that this has been completed by staff for the last 12 months.	Staff responsible for medication management complete a formal competency assessment and this is documented. 90 days
Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing	PA Low	Restraint use is evaluated for individual residents as part of their six monthly medical review, rather than as a facility wide activity. The restraint coordinator is new to the role and is pro-actively learning the role. There is oversight of restraint use by the clinical committee which is a group of nursing staff and board members who are experienced health professionals. The extent of restraint use, progress in reducing restraint, and adverse outcomes are known to staff, however the other requirements of this standard have not been met.	Comprehensive review of all restraint practice was not occurring at the time of audit.	Instigate comprehensive review of the restraint use at Wharekaka Rest Home to comply with policy and this standard. 90 days

education.				

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.