# Experion Care NZ Limited - Wensley House

## 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 Q-Audit 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Experion Care NZ Limited

**Premises audited:** Wensley House

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 9 May 2019 End date: 10 May 2019

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 27

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

Wensley House provides rest home care for up to 30 residents. The service is operated by Experion Care NZ Limited and managed by a general manager and a clinical services manager. There were 27 residents at the time of audit. 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 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.

Six areas were Identified as areas of improvements relating to quality management, residents care plans, maintaining up to date medications, food services, maintenance in communal showers, shelves in the laundry areas and Infection Prevention and Control education.

## 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. |

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

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

If a resident should identify as Māori a plan is in place to ensure their needs are met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

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

A complaints register is maintained with complaints resolved promptly and effectively. There are no outstanding complaints.

## 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. |

Business, quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system include 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. A systematic approach to identify and delivers ongoing training supports, safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The clinical nurse manager (CNM) and clinical nurse leader (CNL) are responsible for completing all the required assessments, development and evaluation of care plans. Short term care plans are developed for any acute needs as required.

Planned activities are appropriate for the residents’ assessed needs and abilities. Residents and family/whanau interviewed expressed satisfaction with the activities provided by the activity coordinators.

The service uses an electronic medication system. Medication is administered by staff with current medication competencies. Three monthly reviews are completed by the attending general practitioners (GPs).

Nutritious meals, snacks and fluid are provided and meet nutritional needs and preferences of residents. Residents who require special or modified meals are catered for.

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

The facility meets the needs of residents and is clean. 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 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. |  | Standards applicable to this service fully attained. |

Wensley house has a philosophy and practice of no restraint. On the days of audit there were no restraints or enablers in use. Policies and procedures meet the requirements if a restraint is required. Staff education in restraint minimisation and challenging behaviour is ongoing.

## 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. |

The infection control management system is in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Documentation evidenced that relevant infection control education is provided to staff. Infection data is collated monthly and analysed and reported during staff and management meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## 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 | 39 | 0 | 3 | 3 | 0 | 0 |
| **Criteria** | 0 | 86 | 0 | 4 | 3 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | Wensley House 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 verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form. 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 | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The manager provided examples of the involvement of Advocacy Services in relation to the complaints process. |
| 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. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew 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 show any required follow up and improvements have been made where possible. The general 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. There has been one complaint received from external sources since the previous audit, this is now closed. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided. The Code is displayed in the main foyer together with information on advocacy services, 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.  Residents are encouraged to maintain their independence by community activities, and participation in community activities of their choosing. 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 and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. |
| 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 | Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. 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. One Māori resident interviewed identify themselves as Māori, staff acknowledge and respect their individual cultural needs. |
| 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 culture, values and beliefs and that staff respected these. Resident’s personal preferences required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, palliative care team, wound care specialist, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.  Another example of good practice observed during the audit is the recent introduction of medication e prescribing, the general manager reported the number of medication incidents has significantly reduced. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff know how to access interpreter services, though reported this was rarely required due to all residents being able to speak English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A sample of monthly reports to the board of directors which includes the owner showed adequate information to monitor performance is reported including performance, emerging risks and issues.  The service is managed by a general manager (GM) who holds relevant qualifications and has been in the role for two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The GM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through education related to residential aged care management. Recent management changes include the employment of an experienced senior registered nurse as a clinical manager, to oversee clinical service delivery.  The service holds contracts with DHB and MoH for complex medical conditions as well as palliative/end of life care. At the time of audit 27 residents were receiving services under the contract, there were no residents under the age of 65 years. |
| 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 general manager is absent, a clinical manger carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a senior carer who 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, audit activities, a regular patient satisfaction survey, monitoring of outcomes and clinical incidents including infections.  Wensley House policies and procedures have been developed by an aged care external consultant contractor. An improvement is required to ensure all Policies and procedures meet the requirements of the standard.  Staff have access to hard copies of policies and procedures which are located in the specific areas of use.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at staff meetings. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed residents were satisfied with services.  The general manager described the process for the identification, monitoring, reviewing and reporting of risks and development of mitigation strategies. The general manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. |
| 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 | Staff document adverse and near miss events on an incident form. A sample of incident 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, analysed and reported to the board and at staff meetings. Staff confirmed that they are made aware of their responsibilities in this regard during their orientation and in policy and procedures.  The general manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of significant events made to the local district health board, since the previous audit, this has been resolved.  A Clinical Nurse Manager (CNM) has recently been appointed, (0.6FTE) who’s role is to oversee all clinical aspects of patient care. The CNM has wide knowledge of the sector and currently works in a similar position at another similar facility in the region.  The service has a hazard register that identifies the hazards in the facility and delivery of services. This includes minimization strategies to address the risks associated with service provision. The internal auditing system, hazards checklists and inspections are implemented to monitor on-going compliance. |
| 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 are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, reference checks and validation of qualifications and practising certificates (APCs), where required. Role descriptions are available for all staff members positions and is consistent to the staff members qualifications. 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 show 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. All staff participate in continuing education. The individual records of education are maintained for each staff member sampled. All relevant staff have medication competencies.  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. |
| 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). The facility 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 a roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24//7) coverage.  In addition to care staff, there are sufficient numbers of activities coordinators, cooking, cleaning, laundry administration and maintenance staff to meet the needs of the residents.  Residents and families interviewed reported that there was enough staff to provide them or their relative with adequate care. Observations during the audit confirmed adequate staff cover is provided. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP notes. This includes interRAI assessment information entered into the Momentum electronic database (refer 1.3.5.2). Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed.  No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Wensley House’s information pack contains all the information about entry to the service. All enquiries are captured, and records kept. Assessments and entry screening processes are documented and clearly communicated to residents or family/whanau of choice where appropriate, local communities and referral agencies.  Records sampled evidenced that all entry requirements were conducted within the required time frames. Family/Whanau and residents interviewed confirmed that they received sufficient information regarding the services to be provided. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents’ records to confirm this. |
| 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 Moderate | An annual medication competency is completed for all staff administering medications and medication training records were sighted. The carer was observed administering medicines following the required medication protocol guidelines and legislative requirements. Standing orders are used when required in consultation with the CNM and CNL.  The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted, and all medications are stored appropriately. There was no resident self-administering medicines and a self-administration policy is in place when required. As required (PRN) medications held in stock had expired and outcomes of PRN medicines administered were not documented in the residents’ electronic medication file and progress notes. |
| 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. | PA Moderate | Food services are provided on site by a cook and other kitchen staff. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Labels and dates were on all containers sighted. The kitchen and pantry were regularly maintained to good hygiene standards. Records of food, fridge, freezer temperature monitoring were maintained.  A dietary profile is completed on admission and updated every six months or earlier if required. Personal food preferences, any special diets and modified texture requirements are catered for. Monthly weights are completed and residents with weight issues are provided with nutritional supplements. All the residents and family interviewed expressed satisfaction with the food provided. However, it was noted that the food service was not registered under the new food control plan, inhouse audits were inconsistently completed and kitchen staff had no food handling training. |
| 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 | The general manager reported that when a consumer is declined entry, family/whanau and are informed of the reason for this and made aware of other options or alternative services available. Any risks are managed accordingly, and the consumer is referred back to the referral agency to ensure that the consumer will be admitted to the appropriate service provider |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial assessments are completed within the required time frames on admission. Care plans and interRAI assessments are completed refer 1.3.5.2. Assessments and care plans are detailed and are completed in consultation with the family/whanau and other health team members as appropriate. In interviews conducted residents and family/whanau expressed satisfaction with the assessment process in place. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Care plans are resident focussed, integrated and provide continuity of service delivery. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care. An improvement is required to ensure that care plans reflect outcomes from interRAI assessment tools. |
| 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 documented interventions in short term care plans and long-term care plans were developed to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Clinical supplies are adequate, and the staff confirmed they have access to the supplies and products they needed. |
| 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 | Activities are planned and provided/facilitated to develop and maintain strengths, skills, resources and interests. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. Residents are kept informed about daily activities through activity planners posted on notice boards as well as by word of mouth. Activities include individual, group and van outings. The residents were observed to be participating in meaningful activities on the audit days and going offsite with family/whanau and friends. There are planned activities and community connections that are suitable for the residents. Attendance is noted on a daily basis and activities plans are reviewed every six months by the activity’s coordinators in consultation with the CNM and CNL respectively (refer 1.3.5.2). The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long-term care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Relatives and staff input are sought in all aspects of care. The evaluations record how the residents are progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when acute problems have resolved. |
| 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 | There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Residents and family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GPs. |
| 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 | 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 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 their purpose. | FA | A current building warrant of fitness (expiry date 14th May 2019) is publicly displayed.  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, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure hazards are minimised in the environment, that residents are safe, and independence is promoted.  External areas are safely maintained and are appropriate to the resident groups and setting.  Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are 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. | PA Low | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes rooms with ensuites. Refurbishment has been completed on one of the communal showers and toilet rooms. An area identified for improvement relates to communal showers and the laundry.  Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident 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 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, wheelchairs 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 | Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.  There is a small designated cleaning team who have 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 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 | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 13 March 2019. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in March 2019. The orientation programme includes fire and security training. Staff 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 residents. Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested.  Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside gardens or small patio areas. Heating is provided by ceiling heaters in residents’ rooms and wall heaters 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 provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The role of the infection control coordinator is held by the CNM who has access to external specialist advice from the GP practice and DHB infection control specialists when required.  The infection control programme is approved and reviewed annually. Infection rates are discussed at monthly staff and quality meetings. Staff are made aware of new infections through daily handovers on each shift and reporting. The infection control programme is appropriate for the size and complexity of the service.  There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. The GM stated that they reported 11 suspected influenza infections over a period of four months under section 31 to the ministry of health but laboratory samples were negative. Infection control guidelines are adhered to in case of outbreaks. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| 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 infection control coordinator is responsible for implementing the infection control programme and the GM indicated there are adequate human, physical, and information resources to implement the programme. Collation, analysis and reporting of infection statistics are completed and discussed at monthly staff and management meetings. The infection control coordinator has access to all relevant resident data to undertake surveillance, internal audits and investigations. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The service has documented policies and procedures in place that reflect current good practice. Staff were observed to be following the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | PA Low | The training content meets best practice and guidelines and a record of attendance is maintained. External contact resources included: GP practice, laboratories and local district health boards. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. An improvement is required to ensure the infection control coordinator maintains their knowledge of current practices by attending infection control training. |
| 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 of infections is carried out as specified in the infection control programme. The infection control coordinator reviews all reported infections, and these are documented. New infections and any required treatment plans are discussed at handover, to ensure early intervention occurs. Infections are recorded, and this information is collated monthly, reviewed and analysed by the infection control coordinator who will advise staff and management of the outcome.  Attending GPs are notified if there is any resistance to antimicrobial agents and evidence of GP involvement and laboratory reporting was sighted. Surveillance programme is reviewed during the infection control programme review. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Wensley House has a philosophy and practice of no restraint. There were no restraints nor enablers in use on the days of the audit. The restraint minimisation and safe practice policy clearly defines the difference between restraint and enablers, and required forms and processes are available if a restraint is required. Staff receive ongoing education in restraint minimisation and challenging behaviour. The CNM is the designated restraint coordinator. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | The policies and procedures have been developed by an aged care consultant external contractor. The policies and procedures have not been adapted to reflect the specific needs of the organisation. | Policies and procedures have not been adapted to contain the details specific to Wensley house. | Provide evidence that the policies and procedures are adapted to contain specific details to the facility.  180 days |
| Criterion 1.2.3.4  There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. | PA Low | There is no current process or system to ensure all documents are controlled (also refer to 1.2.3.3) | There is no current document control system or authorisation date, authoriser and/or review date. | Provide evidence that a document control system is introduced for all policies and procedures.  180 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medications are stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the CNM or CNL when the resident is transferred back to service. All medications are reviewed every three months and as required by the GPs. Allergies are clearly indicated, and photos current for easy identification. An improvement is required to ensure expired PRN medicines held in stock are replaced and returned to the pharmacy and outcomes of PRN medicines administered are documented to monitor effectiveness. | PRN medicines held in stock were expired and not returned to the pharmacy.  Outcomes of PRN medicines administered were not documented in the residents’ electronic file and/or progress notes. | Ensure that all medications held in stock are current and not expired.  Provide evidence that outcomes for PRN medicines are documented.  60 days |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Moderate | The menu complies with recognised nutritional good menu planning practices appropriate for older people and follows a summer and winter four-week rotated menu pattern. The menu was reviewed by a registered dietitian in January 2019; however, the food service is still to be registered under the new food control plan, internal audits were inconsistently completed and kitchen staff had no food handling training. | The food service did not meet current legislative requirements. | Provide evidence that the food service is registered under the new food control plan, internal audits are consistently completed and all staff in the kitchen have food handling training.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Long term and short- term care plans were detailed, current and covered aspects of service delivery however not all reflected outcomes from interRAI assessment tools. | Both long term and activity care plans did not reflect some outcomes from interRAI assessment tools. | Provide evidence that the care plans reflect outcomes from interRAI assessment tool.  60 days |
| Criterion 1.4.3.1  There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use. | PA Low | There are still uneven wall and floor surfaces making it difficult to clean in the other communal showers and toilets. The laundry has shelves that require action to ensure all services can be easily cleaned. | Work in one of the communal showers has been completed. However, there are still shelves in the laundry and bathroom wall and floor surfaces that require action. | Provide evidence that the laundry shelves and shower areas are repaired to ensure all surfaces meet good infection control requirements.  90 days |
| Criterion 3.4.1  Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. | PA Low | Staff education on infection prevention and control is conducted by the infection control coordinator and other specialist consultants. The ICC had not attended any infection control training on current practices in the last year. | No evidence sighted to confirm infection control coordinator had attended infection control training to maintain knowledge of current practices. | Provide evidence to show that infection control coordinator maintains knowledge of current practice on infection control.  180 days |

# 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.

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End of the report.