

Heritage Lifecare Limited - Waiapu House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Heritage Lifecare Limited

Premises audited: Waiapu House

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 19 September 2019 End date: 20 September 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: 67

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 |
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| | 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 |
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| | 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

Waiapu House Lifecare is owned and operated by Heritage Lifecare Limited (HLL). The home provides rest home and hospital level care to a maximum of 74 occupants. The care home and village manager and the clinical services manager were available for this audit and both are experienced in this sector.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, family members, managers, staff and allied health professionals. The general practitioner was unavailable to be interviewed.

The manager reported there have been no changes to size or scope of the service since the previous audit.

The one area identified for improvement in the last audit in relation to consumer information was fully addressed. There were four areas identified as requiring improvement related to quality and risk management and human resources management.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Business and quality and risk management plans include the scope, direction, goals, values and mission 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 care home and village.

The quality and risk system and processes support effective, timely service delivery. Policies and procedures are developed nationally and are available for staff reference. The quality management systems include hazard identification and management,

compliments, complaints management, incident/accident reporting, monitoring clinical and non-clinical indicators, resident, relative and staff satisfaction surveys, and monitoring the use of enablers and restraint.

Recruitment practices align with current accepted practice. Applicable staff and contractors maintain current annual practising certificates. Residents and families confirmed during interview that their needs were being met. There is always at least one registered nurse on duty.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Standards applicable to this service fully attained. |
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including the registered nurses and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

Medicines are safely managed and administered by staff who are competent to do so.

Nutritional meals, snacks and fluids are provided in line with recognised nutritional guidelines. Special dietary requirements are catered for. Residents verified satisfaction with meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

The facility has a current building warrant of fitness. There have been no changes required to the fire evacuation plan. Regular fire drills are conducted.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. One resident was using enablers and two residents were using restraints at the time of audit. The use of restraints and enablers is monitored monthly.

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 (ICC), aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 15 | 0 | 1 | 1 | 0 | 0 |
| Criteria | 0 | 36 | 0 | 1 | 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](#).

For more information on the different types of audits and what they cover please click [here](#).

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld. | FA | <p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and is available at the main entrance. Residents and family members interviewed knew about the complaints process.</p> <p>The complaints register reviewed detailed the complaints, dates, and actions taken, through to an agreed resolution for the closed complaints. The communications with the complainant are timely and documented. Two complaints have been received via the Health and Disability Commissioner's Office since the last audit. One complaint was received in July 2018 and one in July 2019. These complaints remain open. The CSM was able to describe several changes that have been made since the first HDC complaint to systems and processes. Implementation of these changes was observed including by the auditor reviewing service delivery.</p> <p>The care home and village manager is responsible for complaints management and follow up. Staff interviewed confirmed an understanding of the complaints process and what actions are required.</p> |
| Standard 1.1.9: Communication Service providers communicate | FA | Staff interviewed understood the principles of open disclosure which are supported by policies and procedures that meet the requirement of the Code. Residents and family members are asked during admission about when communication is to be made by staff with family members following accidents or incidents. Family members interviewed stated they were kept well informed about any changes to their relative's health status and were |

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| <p>effectively with consumers and provide an environment conducive to effective communication.</p> | | <p>advised in a timely manner about any incidents or accidents. These communications were documented in the resident's progress notes and incident records sampled. The family are also contacted about the outcomes of regular and / or any urgent medical reviews.</p> <p>Interpreter services are available if required. Staff knew how to access services, although reported this had not been required for some time. Some staff are able to communicate fluently in other languages and can converse with residents and family members in the resident's first language as required during cares.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of reports to the regional operations manager and regional clinical and quality supports showed adequate information to monitor performance is reported including occupancy, complaints, incidents and any other emerging risks and issues.</p> <p>The service is managed by the care home and village manager who was appointed to this role in December 2018. The care home and village manager is a registered nurse with a current annual practising certificate (APC) and works full time on site. The care home and village manager is assisted by the fulltime clinical services manager (CSM) who has been in this permanent role at Waiapu House since April 2018. The care home and village manager reports the management team works very well together to ensure the day to day functioning of the facility is occurring in an appropriate manner and the care needs of residents are met. The care home and village manager is appropriately experienced, and has exceeded the professional development as required to meet the provider's contract with Hawke's Bay District Health Board (HBDHB). The care home and village manager confirmed knowledge of the sector, regulatory and reporting requirements.</p> <p>There were 67 residents present on the first day of audit. The service holds a contract with Hawkes Bay District Health Board (HBDHB) for the provision of Age-Related Residential Care (ARRC) at rest home and hospital levels of care. Other contracts are held with HBDHB for Long Term Support, Chronic Health Conditions (LTS CHC); 'Restore in ARRC Residential Care (Aging in Place – Short Stay-Transitional Care Facility); EngAGE in ARRC residential care services; Respite and Day Care Services for ARRC; and Mental Health in ARCC. The care home and village manager advised that while some of the contract documents sighted were for the previous year, all the contracts have continued and the new signed documents will be available on site in due course.</p> <p>At the time of the audit there are 45 residents receiving rest home level of care and 18 residents receiving hospital level of care under the ARRC contract. In addition, three residents under 65 years of age are under the LTS CHC contract (two at rest home and one at hospital level care), and one resident is receiving services under the mental health in ARCC contract.</p> <p>The day care services were not included in the scope of this audit.</p> |

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| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | PA Low | <p>Waiapu House Lifecare has a quality and risk management system which is understood and implemented by service providers. A continuous improvement focus is noted. The quality and risk programme include resident, relative and staff annual satisfaction surveys, incident and accident reporting, health and safety reporting, hazard management, monitoring the use of restraint, and complaints / compliments management. Clinical and non-clinical indicators are reported on monthly. Analysis is occurring of themes and trends over time in Waiapu House and possible contributing factors identified.</p> <p>The results of the resident and relative satisfaction survey are reviewed and analysed by the national support office. The results of the 2019 survey have just been released. The care home and village manager has yet to evaluate the findings and noted once reviewed would communicate the results with staff. The feedback from 13 residents and 23 relatives at Waiapu House is included in the analysed reports.</p> <p>Policies and procedures were readily available for staff. Policies are to be reviewed two yearly or sooner where required. These are developed nationally for Heritage Lifecare Ltd (HLL) and distributed. The administrator is responsible for document control processes. New or significant changes to document content are discussed with staff at various meetings.</p> <p>Minutes of caregiver meetings are not being consistently recorded; many of the scheduled internal audits are overdue, and corrective action planning is not consistently documented and/or reviewed. These are areas requiring improvement.</p> <p>Resident and family members interviewed were happy with the services provided at Waiapu House, except for aspects of staff training (refer to 1.2.7.4 and 1.2.7.5).</p> <p>Actual and potential hazards and risks are identified in the risk and hazard registers. These contained potential and actual hazards and risks. Mitigation strategies have been documented. Staff confirmed that they are required to report hazards and maintenance issues. Examples of these communications with the health and safety coordinator and maintenance staff were sighted. The care home and village manager is required to provide the regional operational manager with regular formal written reports. These are now monthly (previously weekly). This includes reporting on any emerging or changing risk. The care home and village manager advised these would also be communicated verbally at the time any new concerns were identified.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p> | FA | <p>Policy and procedure detail the required process for reporting incidents and accidents and near miss events. A paper based reporting system is in use. Staff advise they are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme, for example falls prevention. Records are not available to demonstrate staff have consistently completed orientation and ongoing education requirements (refer to 1.2.7.4 and 1.2.7.5).</p> |

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| <p>untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | | <p>Applicable events are being reported and actions taken in response to incidents are documented and monitored for effectiveness. Staff report accidents/incidents and were observed to discuss reported events during their shift handover. The CSM is responsible for review and oversight to ensure appropriate actions have been taken. The events are recorded on a register in individual resident's files as observed during audit. A review of incidents including falls, skin tears, bruising, challenging behaviour, a staff injury, and medicine related events demonstrated investigations were conducted and appropriate actions taken in response to each event. Family members verified they had been informed of relevant events in a timely manner. The events are also referenced during the residents' care plan reviews.</p> <p>A range of events are monitored monthly as clinical and non-clinical indicators by the CSM. The indicators included falls with and without injuries, skin tears, pressure injuries, weight loss, behaviours, restraint/enabler use, compliments/complaints and infections. Analysis occurs each month with trends and general discussion points noted. These are discussed at the applicable staff meetings, although minutes are not always documented for caregiver meetings (refer to 1.2.3.6).</p> <p>The care home and village manager advised that three essential notifications have been made in relation to services in 2019. This includes a section 31 notification about pressure injuries present on a resident on admission, newly developed pressure injury, and the temporary planned shutdown of fire sprinklers. Records related to five essential notifications made in 2018 were sighted. This included about the change in the care home and village manager in December 2018, pressure injuries, and a resident who was absent without staff prior knowledge.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>PA Moderate</p> | <p>Recruitment processes include completing an application form, conducting interviews and reference checks. Police vetting is occurring and is facilitated by staff in the Heritage Lifecare Ltd (HLL) national support office. An employment contract and a confidentiality declaration are in staff members' files. Staff are to read and sign the HLL code of conduct.</p> <p>Records are available that demonstrate all registered health professionals (both employed and contracted) have a current annual practising certificate.</p> <p>There are five volunteers who assist with the activity programme. They are required to complete a questionnaire, sign a confidentiality agreement, code of conduct and undergo police vetting. Where applicable copies of their drivers licence and first aid certificate is on file. The volunteers work under the delegation and oversight of the diversional therapist and activities staff.</p> <p>Staff are provided with an orientation relevant to their role. Records of completion are not consistently maintained. While ongoing education has been provided, this has not been as frequent as planned/required. These are areas requiring improvement.</p> |

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| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>There is a documented 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 four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Agency staff are obtained when the staffing requirements are unable to be met by employed staff. The care home and village manager and the CSM are both experienced aged care RNs with current APC's and they work clinically where required to ensure the care needs of the residents are met. This includes the CSM completing many of the interRAI assessments (refer to 1.2.7.5).</p> <p>At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage on site.</p> <p>The care home and village manager advised during the day designated staff respond to calls for assistance from residents in the village. This includes the village coordinator who works weekdays. After 5pm village residents are advised to use their personal emergency alarms if required as Waiapu House staff are not available to respond to calls.</p> <p>There are currently two full time position RN vacancies and one caregiver vacancy. The service is recruiting for three RNs. One RN candidate is reported to be awaiting a visa from the Immigration services.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical notes were current and integrated with GP and allied health service provider records. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Registered nurses are using stamps with their full name, registration number and designation when making entries into the hard copy records. This was an area identified for improvement from the previous audit which is now closed out. Archived records are securely held for the required period and are retrievable when needed. No personal or private resident information was on public display during the audit.</p> |
| <p>Standard 1.3.12: Medicine Management</p> | FA | <p>The staff observed administering medicines demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Current medication administration competencies were sighted for</p> |

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| <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | | <p>all staff who administer medication.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription when medication is received from the pharmacy. All medications sighted were within current use by dates. The service has implemented an electronic medication management system. Staff have completed relevant training for the new system and other topics required for medicine management as per the training records.</p> <p>Interviewed staff demonstrated knowledge on controlled drugs management and storage requirements and are guided by the medication management policies and procedures when required.</p> <p>The required three-monthly medication review is consistently recorded on the medicine chart by the GP. On the reviewed medication charts, dates were recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were met. Monthly reviews/audits are completed from the electronic system utilised and reports were sighted.</p> <p>There was one resident who was self-administering oxygen at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>The food service is provided on site by two cooks and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows a four weekly cycle pattern. The service has a contracted dietitian who has audited the menu plans within the last two years.</p> <p>Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the food safety plan. The two cooks interviewed have undertaken a safe food handling qualification. Kitchen hands have also completed all relevant training and certificates are displayed.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Food allergies are documented and included in the care plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>The service has a current food control plan which expires 10 January 2020. This is displayed at the entrance to the facility.</p> |

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| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident. The GP medical records verified that medical input is sought in a timely manner that medical orders are followed, and care is implemented as required. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. Interviewed residents and families confirmed satisfaction with the care provided.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The activities programme is provided by a diversional therapist (DT) having completed the training for the National Certificate in Diversional Therapy and two activities coordinators. The activities staff also assist residents over the meal times in the dining rooms as needed. Five volunteers assist with activities when available. The activities staff provide a monthly report to management on the activities programme. Residents and family members interviewed stated there are days when there are insufficient activities staff available. The diversional therapist interviewed stated that some days the activities are managed by one staff member if some residents are on van outings and one-on-one activities are required.</p> <p>Social assessment and history are conducted on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly and as part of the formal six monthly interRAI and care plan review. A follow up is completed with residents, if changes in activities participation is identified and review implemented to capture the residents' current abilities and interests. There is a resident chaplain for this service and a chapel is on site which is used regularly for church services and special occasions.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed satisfaction with the activities programme. One-on-one activities are provided to cover hospital level care residents unable to join in the programme implemented as and when the need arises.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p> | FA | <p>Resident care is evaluated on each shift and reported in the progress notes by the care staff. If any change is noted, it is reported to the RNs. The RNs review and document in the progress notes when there is need or changes in residents' conditions and weekly as a minimum. One of the senior registered nurses discussed the Waiapu House schedules for the RN primary nurses to complete the interRAI assessments, lifestyle care plans and arrange the GP review dates in a timely manner. The RN interviewed is also a preceptor for students updating to meet the requirements of the New Zealand Nursing Council and one student was interviewed. The interRAI</p> |

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| comprehensive and timely manner. | | <p>assessments are currently up-to-date despite being two registered nurses down on their staff ceiling (refer to 1.2.7.5).</p> <p>Care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessments, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated for acute infections and wounds in the reviewed files. Unresolved problems were added to the long- term care plans after three weeks. Residents and families/whānau interviewed confirmed involvement in evaluation of progress and any resulting changes. Short term care plans were closed off when the short-term problems have been resolved.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>A current building warrant of fitness (expiry date 1 March 2020) is publicly displayed. The external contractor responsible for undertaking test and tagging of electrical appliances is on site. There have been no changes to the facility that have required a change in the approved fire evacuation plan. Staff attend fire evacuation/fire safety training. A fire drill had been scheduled and occurred early afternoon on the first day of the unannounced surveillance audit. Later in the same day, staff implemented the fire evacuation procedures following a fire alarm being activated. The Fire Service attended, and the cause of the fire alarm was identified, and this was not due to either fire or smoke.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The ICC reviews all reported infection, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. The clinical indicator monthly summary was reviewed. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against the previous month and year and this is reported to all staff and the infection control committee. Data is benchmarked externally with the other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate</p> | FA | <p>The nominated restraint coordinator who is the clinical services manager, is carrying out the tasks allocated in the role description. The restraint register noted one resident is voluntarily using bedrails as an enabler and two residents who could not consent were using bedrails for safety. The dates and details for assessment, consent or approval, monitoring and review for the resident using an enabler and the one resident file sampled using bedrails</p> |

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| that the use of restraint is actively minimised. | | as a restraint were consistent with the organisation's policy and these standards. The restraint coordinator expressed a clear intent to minimize and eventually eliminate all restraints. Two family members of a resident using bedrails as an enabler confirmed these were used at the resident's request to promote freedom of movement. The use of enablers and restraints is reviewed monthly as a component of the RN/EN and team leader meeting. |
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | <p>Quality information is shared with all staff via shift handover as well as via the monthly registered nurse/enrolled nurse (RN/EN) and team leader meetings, and the health and safety quality and risk meetings. The minutes of these meetings are made available to applicable staff. While there is a monthly meeting for caregivers that includes quality and risk, service delivery and operational matters, minutes of only one meeting (February 2019) have been documented.</p> <p>There is an internal audit schedule which cover relevant aspects of service including (but not limited to), aspects of care, clinical practice, the facility, documentation and medicine management. The internal audits scheduled for March to July 2019 had not been completed except for those related to hot water temperature testing and chemical management. Designated staff were allocated these and new audits in late August 2019 in order to ‘catch up’. While some audits have been completed, many remain outstanding. Actions plans have been recently documented for the audits completed in January and February. Refer also to criterion 1.2.3.8.</p> | <p>While quality and risk issues are discussed at caregiver monthly meetings, only one meeting (February 2019) has been formally documented in minutes in order to share the information discussed with staff that were not present.</p> <p>Many internal</p> | <p>Consistently record the discussions occurring at caregiver meetings so any staff not present can be kept informed.</p> <p>Undertake internal audits as scheduled and act upon the results.</p> |

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| | | | audits have not been completed as scheduled in 2019. | 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 Moderate | If an issue or deficit is found, a corrective action was put in place to address some situations. This included following individual incidents / accidents and in response to complaints or maintenance concerns and hazards sampled. However, corrective action plans have not been consistently developed following internal audits or had not been developed in timely manner and/or monitored for effectiveness. Corrective action plans have been developed in the last three weeks in response to findings identified in internal audits conducted earlier in 2019. The timeframe for actions required as detailed in meeting minutes are not consistently time framed or monitored for effectiveness. | While there are some examples of appropriate corrective action planning, this is not consistent. Some corrective action plans have been developed months after internal audits. Time frames for corrective actions are not consistently identified and/or evidence the follow-up and completion. | Ensure corrective action plans are consistently developed in a timely manner when improvements are identified, are implemented and monitored for effectiveness. 90 days |
| Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Moderate | Staff advised they are required to complete a health and safety induction and an orientation programme relevant to their role. A workbook / checklist is utilised to ensure all relevant topics and competencies are included. New employees are buddied with senior staff for orientation shifts. The duration of orientation depends upon the new staff member's previous experience and their role. Three new staff (employed between three and four and a half months prior to the audit) reported feeling supported during their orientation by the staff and management team. Records were not available to demonstrate that all staff have completed orientation requirements as observed in some sampled staff files. There were missing or incomplete records in four staff files | Records are not available to demonstrate all staff have completed orientation requirements relevant to their roles. | Ensure all staff complete the organisation's orientation requirements as relevant to their role and records are retained. |

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| | | <p>reviewed – for staff employed between January 2018 and June 2019. The sample size of staff files reviewed was expanded. A register has been recently developed to enable the management team to more closely monitor this aspect. This noted that at least 15 staff who have been employed between January 2018 and July 2019 have not completed all of the organisation's orientation requirements.</p> | | 90 days |
| Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | <p>A staff education programme is in place. The topics are included to align with Waipu House Lifecare's contract with HBDHB, residents' care needs, and in response to quality and risk data and some in-service education has been provided. The CSM has registered to undertake industry approved training in order to become an approved assessor. This is in order to be able to assess caregivers as they work towards completing an industry approved qualification.</p> <p>There are insufficient staff trained to complete interRAI assessments. There are currently two RNs and the CSM with current interRAI competency. This includes one RN who has just finished the training and an RN employed in April 2019. One other RN is currently in training. While residents have a current interRAI assessments, many have been done by the CSM. This has impacted on the CSM's time available for other responsibilities including providing education.</p> <p>Some staff have completed education in 2019 including manual handling, first aid, hoist use, restraint minimisation, falls prevention, nutrition for older people and palliative care. Records of education are maintained. The care home and village manager advised of the plan to schedule half day (four hour) in-service sessions, for which staff will be rostered to attend in order to 'catch up' on education requirements. All residents and family members interviewed spoke highly of the staff employed at Waipu House. However, three of seven family members interviewed reported that due to the changes in staff, they were not confident that all staff had been adequately trained for some components of care provided to their relatives.</p> <p>A competency programme for health care assistants and registered nurses is in place and commences during orientation. This included medicine competency for applicable staff, hand hygiene, manual handling/use of the hoist, restraint minimisation and infection prevention and control. Records</p> | <p>Twenty-two staff are overdue by more than one month their annual performance appraisal.</p> <p>There are insufficient registered nurses with current interRAI competency.</p> <p>While some staff training is occurring, the training has not been provided as frequently as planned and three family members expressed they were not confident that all staff had been adequately trained for some components of care provided to</p> | <p>Undertake annual performance appraisals with staff.</p> <p>Provide regular planned ongoing education for staff to ensure new staff are sufficiently trained for their roles and responsibilities.</p> <p>Increase the number of registered nurses with interRAI competency.</p> <p>180 days</p> |

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| | <p>were not available to verify staff have completed all requirements (refer to 1.2.7.4).</p> <p>A discussion is held with new staff three months after employment. Following this annual performance appraisals are to be undertaken. These have not occurred as required with 22 staff overdue annual appraisals by one month or more. For seven staff their last appraisal is dated as occurring in 2017.</p> | their relatives. | |
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.