

Care Alliance 2016 Limited - Waimarie Private Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Care Alliance 2016 Limited
Premises audited:	Waimarie Private Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 January 2021 End date: 29 January 2021
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:	40

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
Yellow	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
Red	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

Care Alliance 2016 Limited - Waimarie Private Hospital provides rest home and hospital level care for up to 52 residents. There are two owners / directors who purchased the facility in March 2017. One owner/director is the business manager responsible for the non-clinical services, and the other is a registered nurse who has the role of senior manager. The clinical coordinator was appointed to the role of clinical manager and a new clinical coordinator appointed in March 2020 when the previous facility manager resigned. The clinical manager is responsible for managing the day-to-day services provided to residents. Residents and families spoke positively about most aspects of 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/whānau members, management, staff, and a general practitioner.

This audit has identified twelve areas requiring improvement relating to the complaints register, policy and procedures, some quality improvement data, corrective action planning, maintaining orientation records, having a staff member with a first aid certificate always on duty, aspects of building maintenance, resident charges, care plans, some aspects of evaluation, dietitian review of the menu and undertaking an annual review of the infection prevention and control programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

Residents who identify as Māori have their needs 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.

The complaints policy details the complaints reporting, investigation and management process and required timeframes.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation's philosophy, mission and vision statement are identified in the strategic and business plan. The business manager, senior manager and the clinical manager work together to meet residents' needs and legislative requirements.

The quality and risk programme included having policies and procedures available, an internal audit programme, incident/accident reporting, hazard/risk management, restraint minimisation, monitoring of restraint and enabler use, and the infection programme. Quality and risk management activities and results are shared amongst the management team and staff.

Recruitment processes align with current accepted practice. New staff are provided with an orientation. Staff are provided with relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates.

Staffing numbers and skill mix aligns with the organisation's policy. There is always a registered nurse on duty. Care staff have completed an industry approved qualification.

There is a safe residents' information management system. Residents' records are kept for the required period.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family/whānau.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents 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.

The food service is provided on site and special needs are catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Waste and hazardous substances are well managed. Staff have available and use appropriate protective equipment and clothing. The facility meets the needs of residents. There was a current building warrant of fitness. Electrical equipment is tested as required. Clinical equipment has undergone clinical calibration/performance monitoring checks. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Chemicals, hazardous substances, and equipment are safely stored. Laundry and cleaning services are undertaken onsite, and services evaluated for effectiveness.

Staff are trained in emergency procedures. Fire evacuation procedures are regularly practised. Call bells are present in bathroom and bedroom areas. Security is appropriately maintained. There is a designated outside area for residents that smoke.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were no restraints in use at the time of audit, and no residents were using enablers. Staff are provided with training on restraints and enabler use during

orientation and as a component of the ongoing education programme. Staff demonstrated a sound knowledge and understanding of the organisation's policies and could detail the processes required in the event that restraints were required to be used.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. 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	35	0	7	3	0	0
Criteria	0	81	0	9	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Waimarie Private Hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed communicating with residents in a respectful manner, 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. This was verified in training records sighted.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Staff were observed to gain consent for day-to-day care. Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Enduring power of attorney (EPOA) was obtained for residents who were unable to consent and advance care planning was encouraged. The EPOA was</p>

		activated for the residents who were unable to consent.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents and family/whānau were given a copy of the Code on admission, which also includes information on the advocacy service. Posters and brochures related to the advocacy Service were displayed at the reception and available in the facility. Family/whānau members and residents spoken with were aware of the advocacy service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family/whānau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family/whānau members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>Waimarie Private Hospital has a policy that details the resident and family members right to make a complaint. The complaints policy reflected a fair complaints system that complies with the Code. During interview, residents, family/whānau members, the managers and staff reported their understanding of the complaints process and this aligns with the policy. Template forms and a drop box are available near the main entrance of the facility so residents and family members can provide feedback or make a complaint at any time.</p> <p>The clinical manager is responsible for complaints management processes with support of the management team. A complaints register is not being maintained. The actions taken in response to the complaints are not consistently documented or monitored for effectiveness (refer to 1.2.3.8).</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family/whānau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff when required. The Code was displayed at the reception area on notice boards around the facility, together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families/whānau 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. Residents have a private room or share a room with their spouse with their consent. The interviewed couple expressed satisfaction with sharing their room and confirmed that consent was obtained.</p> <p>Residents are encouraged to maintain their independence by being supported to attend to community activities. Care plans included documentation related to the residents' abilities, and strategies to maximise independence.</p> <p>Each resident's individual cultural, religious and social needs, values and beliefs had been identified on admission, documented and incorporated into their care plan. This was verified in the records reviewed.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There were two residents and one staff who identify as Maori. 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. Māori residents</p>

		and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences required interventions and special needs were included in care plans reviewed. A resident's file was reviewed for a resident who required special diet due to resident's culture and beliefs and this was provided as requested. The interviewed residents and family/whānau confirmed that individual needs were being met.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Residents and family/whānau 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. This information was included in the staff handbook sighted. All registered nurses have records of completion of the required training on professional boundaries. There were policies and procedures to guide staff. Interviewed staff demonstrated clear understanding of the processes to follow should they suspect any form of exploitation.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service seeks input from external services and allied health professionals, for example, the local hospice team, diabetes nurse specialist, psychogeriatrician, mental health services for older persons and staff education to encourage and promote good practice. Referrals and documentation to verify this was sighted in the reviewed files. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Staff have access to online education sessions.</p>

<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family/whānau members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to most residents able to speak English. Interpreter services are accessed through the local district health board when required. Applicable staff and family/whānau members are able to assist with interpreting for day-to-day activities.</p>
<p>Standard 1.2.1: Governance 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. Documents describe annual and longer-term objectives. These plans are reported to be developed by the owners with input from the clinical manager.</p> <p>Since the last audit there has been a change in management. The previous facility manager resigned in March 2020. The clinical coordinator at the time was appointed as the clinical manager, and a new clinical coordinator appointed. The new clinical coordinator had been working at Waimarie Private Hospital as a RN since June 2018. The responsibilities of the facility manager have been shared between the business manager and the clinical manager roles. Both the clinical manager and the clinical coordinator are experienced registered nurses in the aged related residential care sector. The senior manager is a registered nurse and is responsible for staffing / managing the roster, and supporting the clinical team. The business manager is responsible for human resources, facility/equipment and grounds management, and financial management. The senior manager and the business manager are the two owners and directors of the company Care Alliance (2016)</p>

		<p>Limited.</p> <p>The clinical manager is responsible for ensuring the day-to-day care needs of residents are met, staff training, and most aspects of the quality and risk programme with the assistance of the clinical coordinator. Responsibilities and accountabilities are defined in the clinical manager and clinical coordinator job descriptions and individual employment agreements.</p> <p>As the owner/director's work in the business they confirm they are kept very well informed of any issues that arise at the time they occur. The management team confirmed knowledge of the sector, regulatory and reporting requirements. The clinical manager maintains currency of practice through ongoing education related to aged care and relevant clinical practice as required to meet the providers contract with Auckland District health Board (ADHB).</p> <p>The service holds contracts with ADHB for rest home, hospital, respite, chronic health conditions and interim care services. Thirty-five residents were receiving services under the Age-Related Residential Care contract (22 at hospital level of care- including two receiving respite care), and 13 at rest home level of care. One resident was receiving services under the Long-Term Chronic Care contract, and four residents were receiving care under the Interim Care Scheme Service contract at the time of audit. Residents who receive care under the Interim Care Scheme Service contract have input from designated ADHB staff. Residents receiving services under each contract were included in the audit process.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to</p>	<p>FA</p>	<p>In the clinical manager's absence, the clinical coordinator is responsible for the oversight of care and services provided. The business manager and the senior manager provide advice and support as required. The clinical coordinator is aware of the responsibilities and confirms appropriate information and support is available. The clinical coordinator</p>

consumers.		has worked in aged related residential care services since 2015.
<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>	<p>PA Moderate</p>	<p>Waimarie Private Hospital has a quality and risk management system which is understood and implemented by service providers. This includes internal audits/reviews, incident and accident reporting, health and safety/hazard management, infection control data collection and management, and concerns/complaints reporting.</p> <p>Internal audits are being undertaken. There is an internal audit calendar that details when audits are to be undertaken, and audit templates are used. There is a high level of compliance noted in the findings of some audits. For example, the hand hygiene audit, decontamination of non-clinical equipment and aspects of resident hygiene. Examples of appropriate corrective action planning was sighted. However, this was not consistent. Examples where sighted of internal audits, complaints, and incidents where improvements were identified as being required, however, the actions required were not sufficiently detailed or monitored for effectiveness, although the management team could detail the actions taken.</p> <p>Appropriate quality information is shared with staff via shift handover as well as via the monthly staff meetings, registered nurse, and management meetings. The minutes of these meetings are detailed and made available to applicable staff and managers. The minutes of three of each meetings were sampled. Staff interviewed verified they were informed of relevant quality and risk information. Opportunities for improvement are discussed, along with the organisation's expectations, policies/procedures, incidents/accidents, restraint minimisation, staff education/training, the results of internal audits, and facility/general business activities.</p> <p>Policies and procedures are available to guide staff practice. Some of the clinical polices required review to ensure the content is sufficiently detailed and aligns with current accepted practice. All policies have been noted as reviewed within the last two years. There are three sets of manuals (paper documents) available for staff in the staff room, the clinical managers office and the nursing station. The clinical manager is responsible for document control processes and archiving. Staff</p>

		<p>interviewed confirmed they can access required policies easily and were informed when policy documents have been updated. Requested policies and procedures were sighted during audit.</p> <p>Actual and potential hazards / risks are identified in the electronic hazard register's sighted. There are displayed in each department/area and were reviewed in November 2020. The organisations risk register details a range of organisation risk. The business manager is responsible for reviewing risk management processes to ensure they are current. The management of Covid-19 was noted to be a success with Waimarie Private Hospital going into lockdown before this was required as part of the national alert level. None of the staff and residents developed Covid-19. Each RN on duty write's a shift report which is sent to the entire management team to keep them informed about changing resident needs and clinical risk in a timely manner. Examples of these reports were sighted.</p> <p>There are a number of key performance indicators noted in the quality and risk plan, some of which are not being monitored. A diversional therapist meets with residents one on one to obtain feedback about services in lieu of resident meetings and a resident satisfaction survey. The results of these meetings are not being communicated to the management team or linked to the quality and risk programme.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Policy and procedure detail the required process for reporting incidents and accidents including near miss events. Staff 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. Staff interviewed could detail the type of events that are to be reported (including near miss events) and how they would report applicable events.</p> <p>Applicable events have been reported in a timely manner. Sampled events have been disclosed with the resident and/or designated next of kin. This was verified by residents and family members interviewed, and records of communications maintained in the sampled residents' files, and incident reports.</p> <p>A review of nine reported events including witnessed and unwitnessed</p>

		<p>falls with and without injury, a pressure injury, absconding, and a medication related event, demonstrated that incident reports are completed, and investigated in a timely manner. However, actions taken in response to the events are not consistently documented. This is included in the area for improvement raised in 1.2.3.8.</p> <p>It was noted there is inconsistency in the evaluation of residents post unwitnessed falls. While neurological observations are being undertaken, there is no consistency to the frequency and duration of monitoring for the sampled residents and events. This is included in the area for improvement raised in criterion 1.3.8.2. The falls prevention and management policy required review and updating (refer to 1.2.3.3).</p> <p>Staff are provided with a monthly update on the number of resident falls and skin tears, and advised of individual resident events, and actions required as a component of shift handover.</p> <p>The clinical manager and the business manager are aware of the events that require essential notification. The changes since the last audit in relation to the clinical manager have been reported to HealthCERT. There have been no other events that have required essential notification.</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 Low</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The business manager is responsible for recruitment with assistance of the clinical manager.</p> <p>The recruitment process included completing an application form, conducting interviews, and referee checks. Records are retained of these processes. Police vetting is occurring as staff are employed, and the results noted. Staff are provided with job descriptions, an employment agreement which includes a confidentiality agreement and the organisations code of conduct.</p> <p>All employed and contracted registered health professionals (RHPs) have a current annual practising certificate (APC) and records maintained.</p> <p>While staff confirm they are provided with an orientation relevant to their</p>

		<p>roles, records are not consistently retained to demonstrate this. The orientation provided to bureau/agency staff is not documented.</p> <p>Staff are provided with relevant ongoing education as required to meet the standards and contractual requirements. Records of completion/attendance are maintained. There are a range of topics that are covered by onsite education, and other topics completed online. Staff are informed of the topics each month, and provided with an email link for the online education. The education calendar for 2021 is displayed throughout the facility.</p> <p>There are 23 health care assistants employed. Three staff have completed a level two industry approved qualification, three staff have completed a level three industry approved qualification, and seventeen staff have completed a level four industry approved qualification with one staff member currently in training, as per the summary records sighted.</p> <p>An annual performance appraisal is required for all staff. The clinical manager is responsible for overseeing this process. A register is maintained detailing the dates these are due. Appraisals have been completed for applicable staff or are in progress.</p> <p>The registered nurses are required to have a current first aid certificate and medicines competency, along with specified senior HCA's. Fifteen staff completed first aid training in June 2020. However, there are some shifts where there is not a staff member on duty with a current first aid certificate. This is raised as an area for improvement in 1.2.8.1.</p>
<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>	<p>PA Low</p>	<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. Policy</p> <p>identifies that 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</p> <p>is available when needed. The senior manager is responsible for developing the roster and maintains a register of resident numbers and their level of care. A staff member with a current first aid certificate is not</p>

		always on duty as required.
<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>Residents' information is paper based and electronic for interRAI assessments and medication management. Residents' files were stored securely in a locked cupboard and staff had individual passwords to access the electronic records. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. 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.</p> <p>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.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	PA Low	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families/whānau are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The facility brochure and online information has adequate information for the services provided. The organisation seeks updated information from NASC, GP for residents accessing respite care. For residents receiving orthopaedic interim care, information is received from the acute services they were discharged from.</p> <p>Family members/ whānau and residents interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements. Transport related service charges did not comply with the admission agreement.</p> <p>Waimarie Private Hospital provides rest home, hospital, respite and</p>

		orthopaedic interim care which caters for those residents over the age of 18, requiring non-weight bearing support.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. Communication between all services, the resident and the family/whanau was open. At the time of transition between services, appropriate information was provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a resident recently transferred to the local acute care facility showed that the RN communicated with the receiving service on the phone to handover the resident's care. Family of the resident reported being kept well informed during the transfer of their relative. The clinical manager stated that if the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There was a medication management policy that was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the days of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines were competent to perform the function they manage. Current medication administration competencies were sighted.</p> <p>The contracted pharmacy supply medications in a pre-packaged format. The RN checks medications against the prescription. Electronic records sighted verified this. All sampled medications in the medication trolley and medication storage room were within current use by dates. Clinical pharmacist input was provided on request. The records of temperatures for the medicine fridge and the medication room reviewed were within</p>

		<p>the recommended range.</p> <p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP reviews were consistently recorded on the medicine chart. No standing orders in use. All prescriptions are completed electronically. For residents who were receiving interim support, discharge prescriptions are emailed to the "house doctor" and medication entered into the electronic medicine management system.</p> <p>There was one resident who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Analysis of medication errors were completed and there were processes in place to manage this comprehensively.</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>PA Low</p>	<p>The food service is provided on site by three qualified cooks. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local city council. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The cooks have completed a safe food handling qualification.</p> <p>A diet profile was completed for each resident on admission and it included personal food preferences, any special diets and modified texture requirements, allergies and dislikes. Copies of diet profiles were kept in the kitchen folder and any changes to dietary needs were made known to the kitchen staff by the nursing team. Nutritional supplements were provided for those residents with unintentional weight loss. Special equipment, to meet resident's nutritional needs was available.</p> <p>Interviewed residents and families/whānau reported satisfaction with the</p>

		<p>meals service. Individual resident meeting minutes verified satisfaction with the meals provided. On the days of the audit, residents were seen to be given enough time to eat their meals in an unhurried fashion and assistance was provided to those who required it.</p> <p>Records were not available to demonstrate that the menu in use has been reviewed by the dietitian within the past two years.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The interviewed clinical manager (CM) reported that if a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family/whānau are supported to find an appropriate care alternative. The prospective resident and family will be informed of the reason for the decline. This was verified in the records reviewed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, continence and interRAI to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. InterRAI assessments were current for all residents as indicated by the contractual requirements. There were five trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Not all care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families/whānau reported participation in the development and ongoing evaluation of care plans.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The interviewed GP verified that medical input was sought in a timely manner, that medical orders are followed, and care was promptly implemented. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy (DT). An activities assessment was completed by the DT for each resident to ascertain 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 were evaluated when there are significant changes in residents' ability and attendance and as part of the formal six-monthly care plan review.</p> <p>A monthly planner was developed by two DT's and a weekly planner was posted in each resident's room and on the notice boards around the facility. The activities are combined for both rest home level and hospital level residents. The activities programme reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events were offered. Residents and families/whānau were involved in evaluating and improving the programme through multidisciplinary review meetings and individual residents' meetings with the DT. Residents interviewed confirmed they find the programme satisfactory.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>PA</p>	<p>Care staff documented in the progress notes on each shift and RNs daily. Changes noted were reported to the RN. Regular care plan</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>Moderate</p>	<p>evaluations and interRAI assessments were completed six-monthly or earlier when resident's needs changed. However, there was an interval of five to six weeks between interRAI assessment and care plan review/updating (refer to 1.3.5.2). Improvements are required in relation to neurological monitoring of residents after a fall and regularly monitoring the weight of one resident.</p> <p>The evaluations indicated the degree of achievement or response to interventions implemented to meet the desired outcomes. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for respiratory infections, wounds and eye infections. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents were supported to access or seek referral to other health and/or disability service providers. Although the service has a contracted GP, residents may choose to use another medical practitioner. Where other non-urgent services were indicated or requested, the GP or RN sent referrals to seek specialist input. Copies of referrals were sighted in residents' files, including to the eye specialists, dietitian, and mental health team. The resident and the family/whānau were kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals were attended to immediately, such as sending the resident to acute care services in an ambulance as indicated by the circumstances.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Applicable staff have completed training in the safe handling of chemicals. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of appropriate protective clothing and equipment and staff were observed using this.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>A current building warrant of fitness (expiry 01 June 2021) was publicly displayed.</p> <p>The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with the business manager (who is responsible for oversight of maintenance), as well as observation of the environment. The environment was hazard free. Residents were safe, and independence was promoted. Residents were observed mobilising with and without the use of a mobility device both independently and with staff assistance inside and outside the building.</p> <p>External areas were safely maintained and appropriate to the resident groups and setting. The temperature of the hot water is monitored to ensure it is within the required temperature range. Water checked at random at the tap was an appropriate temperature.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required, and reported maintenance requests have been actioned. There are some areas that need renovation/refurbishment.</p> <p>The facility utilises a taxi service for the transportation of residents to appointments and for activities.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes eight bedrooms with full ensuite facilities and there are two</p> <p>ensuite bathrooms being shared between two rooms. There are separate staff and visitor toilet facilities. Appropriately secured and approved handrails are provided in the</p> <p>toilet/shower areas, and other equipment/accessories are available to promote residents' independence. There are privacy locks on the sampled doors.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are three bedrooms with two beds, and one bedroom with three beds. All other bedrooms are single occupancy. The two rooms with more than one resident are married couples, who selected Waimarie Private Hospital because they could be together. This was verified by the residents during interview. The management team described the process of ensuring this decision was clinically and socially appropriate.</p> <p>Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters, and equipment. Staff and residents were satisfied the bedrooms and furnishings met their needs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Appropriate communal areas are available for residents to utilise. There are four lounge areas and three dining areas which all enable easy access for residents and staff.</p> <p>Residents were observed moving around the facility inside and outside for recreation/socialisation. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs as confirmed during interviews with residents and family members. There is a lift which operates between the two levels of the facility.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site seven days a week by care staff with laundry being undertaken throughout the 24-hour period around resident care needs. The staff in each wing were responsible for laundering the personal and facility laundry for residents in their allocated area.</p> <p>Staff demonstrated a sound knowledge of the laundry processes,</p>

		<p>dirty/clean flow and handling of soiled linen.</p> <p>Facility cleaning is undertaken by two designated staff that work 7 am to 1 pm. There are two cleaning staff on duty each day except Monday and Saturday. The cleaning tasks and frequency is documented.</p> <p>Staff have been provided with relevant training. All chemicals were stored in a lockable cupboard and were in appropriately labelled containers. The residents and family/ whānau members interviewed expressed satisfaction with cleaning and laundry services provided and confirmed their clothes are returned in a timely manner with infrequent exception. Staff were vigilant with ensuring cleaning chemicals or equipment were not left unattended. Cleaning and laundry processes are monitored via the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in</p> <p>their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was</p> <p>approved by the New Zealand Fire Service, on 15 August 2000. The business manager stated this is the fire evacuation plan in use when they purchased the business and there have been no changes to the fire evacuation plan since this time.</p> <p>A trial evacuation takes place six-monthly by an approved provider with a copy sent to the New Zealand Fire Service; the most recent being in July 2020. The business manager advised a fire drill is due and has been booked with the external fire safety contractor.</p> <p>The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p>

		<p>Adequate supplies for use in the event of a civil defence emergency, including food, torches, water, blankets, mobile phones, and gas BBQ's are available to meet the requirements for the number of residents at the facility and Civil Defence and Emergency Managements recommendations for the region.. There are clinical consumables and personal protective equipment (PPE) also available in separate stores from that used on a day to day basis.</p> <p>Call bells alert staff to residents requiring assistance. There is a light outside the room and an alert to central alert panels. The three call bells tested in resident bedrooms and bathrooms during audit were working, and staff answered these promptly. Malfunctioning bells are raised as a maintenance issue. Three residents noted bells are not always answered in a timely manner (refer to 1.2.8.1).</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a set time as part of the afternoon staff duties after visually ensuring all residents are accounted for. Family/whānau members can utilise the intercom at the main door to obtain access afterhours if required.</p> <p>Security cameras are in place in communal areas and outside the facility. The business manager advised he is reviewing options moving forward due to changes in the technology.</p>
<p>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.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. All bedrooms have natural light, opening external windows and many have doors that open onto outside areas. Heating is provided via wall mounted gas heaters or heat pumps in communal areas. There are electric heaters in resident bedrooms. All areas were at an appropriate temperature and well-ventilated during audit. All residents and families/whānau confirmed the facilities are maintained at a comfortable temperature all year round.</p>

		There is one designated external area for any resident that smokes.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	PA Low	<p>Waimarie Private Hospital has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external expert services.</p> <p>The clinical coordinator is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical manager, service manager and tabled at the monthly staff meetings. The IPC committee includes the business manager, service manager, clinical manager, IPC coordinator, and representatives from the care staff.</p> <p>There was signage at the main entrance to the facility that requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> <p>The infection control programme was not reviewed in the last 12 months.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role. He has completed online education on infection prevention as verified in training records sighted. Additional support and information can be accessed from the infection control team at the ADHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. Adequate resources were sighted on the days of the audit.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were in the process of being reviewed and included appropriate referencing. COVID-19 policies and procedures were in place.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by IPC coordinator and online. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when there was the COVID-19 pandemic, staff education on infection control measures were implemented as per the Ministry of Health recommendations.</p> <p>Education with residents was provided on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plans were discussed at handover, to ensure</p>

		<p>early intervention occurs.</p> <p>Internal infection control audits were completed by the IPC coordinator and corrective actions were implemented where required.</p> <p>Monthly surveillance data was collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. Graphs were produced that identify trends for the current year, and comparisons against previous month and this is reported to the clinical manager and service manager. There has not been any outbreaks of infection reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The acting restraint coordinator (the clinical manager) provides support and oversight for restraint management in the facility, should it be put in place. The restraint coordinator is aware of the policies and procedures and their role and responsibilities related to restraint and enabler approval and use and keeping the register up to date.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers. One resident had a lap-belt as an enabler noted in their care plan. Staff advised this is no longer required and no longer in use (refer to 1.3.5.2). Five residents have a bed loop in place as a mobility device to help them get in and out of bed safely.</p> <p>Restraint and enabler information is discussed at monthly staff meetings as part of quality data which is shared. Staff interviewed are aware of how to safely manage both restraints and enablers and confirmed being provided with relevant orientation and ongoing education. This topic was most recently</p>

		provided in May 2020.
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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)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>The clinical manager is responsible for managing complaints with the support of the other members of the management team. One complaint was received via an independent advocacy service in March 2020. This was responded to in a timely manner. The complainant subsequently advised they would not progress the complaint further. There have been at least six other complaints received since January 2020. The clinical manager is unaware of the exact number as a complaints register is not being maintained. The clinical manager is aware of the requirements and timeframes for responding to complaints as required by the Code.</p> <p>There has been one complaint received from an Auckland District Health Board</p>	A complaints register is not being maintained detailing complaints received, dates and actions taken.	<p>Maintain a complaint's register that details all complaints received, dates and actions taken.</p> <p>180 days</p>

		<p>(ADHB) staff member since the last audit and no complaints have been received from the Ministry of Health or the Health and Disability Commissioner. A review of six complaints verified the service acknowledged the complaints in a timely manner. While the clinical manager can detail the interventions that have been subsequently taken in response to the complaint's, these interventions are not sufficiently documented or monitored for effectiveness in two of the complaints sighted. This is included in the area for improvement raised in criterion 1.2.3.8.</p> <p>Staff interviewed confirmed they would bring any resident or family/whānau member's concerns to the attention of the clinical manager, or the registered nurse on duty, or another member of the management team. Residents and family/whānau members interviewed confirmed they were aware of the complaints process.</p>		
<p>Criterion 1.2.3.3</p> <p>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.</p>	PA Low	<p>The clinical manager is responsible for ensuring policies are updated according to a schedule with input from the management team and other applicable staff. Whilst policies and procedures were noted as being reviewed within the last two years, most references noted in the clinical policies are more than 10 years old. The falls policy has been recently updated but does not provide sufficient guidance for staff on the processes if a resident fall who is prescribed</p>	<p>The references for clinical policies and procedures are not current (frequently 10 years or more), although the policy/procedure documents are noted to have been reviewed within the last two years. The falls policy does not provide sufficient guidance for staff in relation to the management of residents that fall.</p>	<p>Review clinical policies and procedures, update references, and ensure content is current and sufficiently detailed to guide staff practice.</p> <p>180 days</p>

		<p>anticoagulants.</p> <p>Staff interviewed confirmed they can access required policies easily and were informed when policy documents have been updated.</p>		
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>There are a number of key performance indicators that are included in the quality and risk programme, however, not all are being monitored. This includes related to episodes of acute dehydration, average medicines used, significant constipation events and some staff related events. Registered nurses advised they try to prevent these clinical events from occurring, and address any reported events however, there is no process in place to link these events with the quality and risk programme. The KPI's note having a target for falls and skin tear events as a rate (or less) per 1000 bed occupancy days. This is not being calculated, although the actual number of events are being reported monthly and trends evaluated and reported on.</p> <p>One of the diversional therapists is meeting with residents one on one to obtain feedback on services in lieu of resident meetings and a resident satisfaction survey. The results of these meetings are not being communicated to the management team or linked to the quality and risk programme.</p>	<p>The organisations quality and risk programme includes a range of key performance indicators (KPI's). Some of these KPIs are not being monitored.</p> <p>Individual meetings with residents are occurring in lieu of having a resident meeting or undertaking a satisfaction survey. There is no formal process of communicating the outcomes to the management team.</p>	<p>Implement a process to monitor key performance indicators as a component of the quality and risk programme.</p> <p>Ensure the results of individualised resident meetings are communicated to the management team and linked to the quality and risk programme as appropriate.</p> <p>180 days</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>Corrective actions are undertaken when areas for improvement are identified. This includes in response to incidents/adverse events, complaints, and internal audits. Some events sampled clearly detailed the required actions, who was responsible and by when, with evidence of monitoring to ensure the required actions had been undertaken and been effective. An example included in response to the documentation audit, a pressure injury, a resident that had a fall, and equipment and maintenance issues. However, this is not consistent. For example, the actions taken in response to two sampled complaints (related to neurovascular monitoring, wound care and another issue) and incidents including a resident absconding, and another resident with bruising, were not sufficiently documented in either a short term and long-term care plan (refer to 1.3.3), or as part of the complaint or incident management documentation.</p> <p>Corrective action plans have been documented following several internal audits including cleaning, laundry management, and aspects of the environment, however there is no evidence of monitoring to ensure the required changes have been made and are effective.</p>	<p>The corrective actions undertaken when areas for improvement are identified in response to incidents, complaints, and internal audits, are not consistently documented or monitored for effectiveness.</p>	<p>Ensure when areas for improvement are required, that the actions required are consistently documented, implemented and monitored for effectiveness.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive</p>	<p>PA Low</p>	<p>Staff interviewed confirm new staff are provided with an orientation to the organisation and to their role and</p>	<p>While staff advise they are provided with a comprehensive orientation programme relevant</p>	<p>Ensure records are retained to verify staff have completed the</p>

<p>an orientation/induction programme that covers the essential components of the service provided.</p>		<p>responsibilities. Staff are buddied with another senior staff member who go through a workbook/checklist with the new employee. Staff advised the orientation duration can vary depending on the experience of the new staff member and the timeframe is extended where required. The current roster has a new nurse being buddied with another nurse for orientation. The new nurse is supernumerary on the roster. However, there is no process in place to ensure all orientation components have been completed and records retained. Orientation records were missing from four out of eight sampled staff files employed.</p> <p>Agency/bureau staff are used. Staff described the orientation and handover that is given to bureau staff before they start the shift, however records are not retained to demonstrate this process and the orientation content.</p>	<p>to their role, records are not consistently retained to demonstrate completion.</p> <p>Records are not retained demonstrating the orientation programme for bureau staff.</p>	<p>orientation programme requirements.</p> <p>180 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Low</p>	<p>Care staff reported there were normally adequate staff available to complete the work allocated to them. Three out of eight residents interviewed noted their call bells are not always answered in a timely manner. The management team were aware of this and have been working with care staff in relation to the timing of when some care/activities are completed during the course of their 12 hour duty.</p>	<p>A staff member with a current first aid certificate is not rostered in duty at all times.</p>	<p>Ensure a staff member with a current first aid certificate is on duty / on site at all times.</p> <p>30 days</p>

		<p>Observations and review of three weeks roster confirmed sufficient staff cover has been provided, with staff replaced for any unplanned absence. Bureau/agency staff are used when required. This is rarely required for HCA shifts, but used on occasions for RN cover. A bureau RN is noted as working two shifts during the week of audit. Effort is made to get the same bureau staff back for shifts. The business manager noted there are no staff vacancies.</p> <p>A RN is on duty 24 hour/seven days a week. All except one RN has a current first aid certificate. There are three shifts on the current roster (weekend and night shifts) where there is not a staff member on duty with a current first aid certificate, and similar events noted on the preceding weeks roster.</p> <p>The healthcare assistants work 12 hour shifts and the RNs work 8 hour shifts. The HCA's are allocated designated residents they are responsible for. The HCA's undertake laundry duties for their allocated residents as time permits over the 24 hour period. There is a minimum of three HCA's and one RN on duty at night. The owners/directors are also on call and assist as required.</p> <p>Two diversional therapist's (DT's) work 9 am to 5 pm weekdays. There are two staff on duty in the kitchen each day covering</p>		
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		<p>7am to 6pm. Two dedicated cleaning staff work 7 am to 1 pm daily, excepting Monday and Saturday when one cleaner is on site.</p> <p>In addition to the rostered RN on duty, the clinical manager and clinical coordinator both work eight hour shifts Monday to Friday mornings. The business manager works at the facility full time and comes on site on the weekends. The senior manager / RN works a rostered shift if required, but primarily works as an extra staff member and assists clinically if required. This was confirmed during RN interviews.</p> <p>There are five RNs with interRAI competency including the clinical manager, the clinical coordinator, and a casual RN.</p>		
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Low	<p>Admission agreements were obtained from all residents within ten days of admission. Signed admission agreements sighted in the reviewed documents. The admission agreements included all the required information including payable fees and additional costs. The admission agreement stated that transport will be provided at no charge for subsidised residents, but residents were paying transportation costs for organised outings included in the activities programme.</p>	<p>Residents were being charged for transportation for arranged activities that were included in the planned activity programme in variance to the organisation's admission agreement.</p>	<p>Provide evidence that transportation for organised outings as part of the activities programme are funded for by the service as per organisation's admission agreement.</p> <p>30 days</p>

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Low</p>	<p>The menu follows summer and winter patterns. There is a four-weekly cycle in place. Food and fluids were served as per menu and residents were provided with additional drinks when required. Food was served in attractive portions that residents required, and additional food was provided if desired. Residents and families interviewed stated that individual needs were being met.</p>	<p>Records were not available to demonstrate that the menu in use has been reviewed by the dietitian within the past two years.</p>	<p>Provide evidence of current menu review by the dietitian.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Care plans were not always updated in a timely manner following interRAI assessments, with an interval at times of five or six weeks. Some residents' identified needs were not included in the care plans reviewed including management of diabetes and the risk of absconding.</p> <p>One resident is noted as using a lap belt as an enabler. This is no longer required, but is noted as required in the resident's care plan.</p>	<p>i) At times there was an interval of five to six weeks between the interRAI assessments and care plan review.</p> <p>ii) The care plans do not consistently include sufficient information to guide staff for example, absconding risk, use of a lap belt, and diabetes management.</p>	<p>Provide evidence that care plans describe the required support and/interventions to achieve the desired outcomes identified by the ongoing assessment process.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Moderate</p>	<p>Neurological observations were completed for the sampled residents who had an unwitnessed fall. However, there is variation in the frequency and duration of monitoring with one resident only having one set of neurological observations completed, another resident was monitored for four hours, while another resident received half hourly</p>	<p>There is inconsistency in the neurological monitoring for residents post unwitnessed fall.</p> <p>A resident has not been weighed since admission although monthly weights have been requested by the dietitian at least two years ago.</p>	<p>Provide evidence that neurological monitoring is completed consistently post unwitnessed falls.</p> <p>Provide evidence that weight monitoring is completed consistently for all residents.</p>

		<p>monitoring for two hours, then hourly for four hours following a residents unwitnessed fall. None were completed according to the organisations policy.</p> <p>Residents have weight monitoring completed monthly if stable and more frequently as clinically indicated by the resident's condition or as ordered by the GP and specialist services. However, one resident on the sampled files did not have weight monitored since admission due to lack of appropriate equipment onsite.</p>		90 days
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	<p>Staff report maintenance requests and equipment issues in a maintenance register that is located at the nursing station. The reported issues have been addressed in a timely manner. It was observed during audit that there are several areas that require painting/refurbishment. For example, the ceiling in the lounge nearest the main entrance has paint peeling off, and the shared ensuite off room 98 has extensive peeling of the surfaces including the walls and doors.</p>	Some areas in the environment require repairs/ maintenance	<p>Ensure areas requiring maintenance /renovation are consistently reported and managed.</p> <p>180 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Low	<p>There is a documented infection control programme that guides the IPC coordinator and quality team on infection prevention and control matters for the facility. The programme described the infection control activities, review and implementing routine IPC policies and procedures, infection identification and</p>	The infection control programme has not been reviewed in the past 12 months as required.	<p>Provide evidence that the infection control programme is reviewed annually as required.</p> <p>180 days</p>

		investigations, monitoring practices employee and residents' health programs and pandemic preparedness planning. The review date on the infection control programme was November 2017 and did not reflect the current practice in the facility.		
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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 of this audit.

No data to display

End of the report.