

M & K Atkins Limited - The Waratah Retirement Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	M & K Atkins Limited
Premises audited:	The Waratah Retirement Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 May 2021 End date: 21 May 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:	52

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

The Waratah Retirement Home and Private Hospital provides rest home and hospital-level care for up to 58 residents. The service is operated by M & K Atkins Limited and managed by the owner/manager. The owner-manager is supported by the clinical manager, assistant clinical manager, administrator and quality systems/auditor monitor. There were 52 residents on the days of the audit. Residents and families spoke positively about the care provided.

This certification audit was conducted against Health and Disability Standards. The audit process included a visit to the facility, a review of policies and procedures, current services, client and staff files, observations, and interviews with the clients, management, and staff, general practitioner (GP), and family members.

The audit has resulted in one identified area requiring improvement relating to medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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All staff demonstrated knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and their family/whānau are informed of their rights at admission and throughout their stay. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.

Residents and family/whānau receive clinical services that have regard for their dignity, privacy, and independence. The residents' ethnic, cultural, and spiritual values are assessed at admission to ensure they receive services that respect their values and beliefs.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence was seen of informed consent and open disclosure in residents' files reviewed. The advocacy service visits the service for staff education and attendance at residents' meetings. All staff interviewed understood residents' rights.

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.		Standards applicable to this service fully attained.
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The organisation is governed by the owner/manager supported by the other co-owner. The operation of the facility is undertaken by the owner/manager who is the facility manager (FM) supported by a clinical manager (CM), assistant clinical manager (ACM), and quality systems/auditor monitor. Organisation performance is closely monitored by the owner/manager in consultation with the other co-owner.

Strategic business and quality plans include the scope, direction, goals, values, and mission statement of the organization. The strategic business, quality risk, and management plan document the organisation's goals and objectives. Effective reporting processes are in place. The organisation's quality and risk management system are used to ensure service delivery is of a

consistently high standard. It includes an audit programme and corrective actions are developed and implemented when deficits are identified.

These are monitored, and the management ensures all data is analysed, collated, and shared with staff. Adverse events are reported and recorded. Policies and procedures are current. Established processes are in place to facilitate client entry to and exit from services. Residents' information is managed efficiently, contains a level of detail relevant to the service, and meets health record requirements.

Human resource processes support good employment practices. All staff receive an orientation. Ongoing training is provided, and staff competency assessments are completed and monitored. Current annual practicing certificates are kept on file. Police checks are undertaken. There are always adequate numbers of skilled staff on duty.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents are assessed prior to entry to the service to establish the level of care. The processes for assessment, planning, provision, evaluation, review, and exit are provided by suitably qualified staff. Care plans and assessments sampled are completed by the nursing team within the required time frames and demonstrate service integrations. InterRAI assessments and individualized care plans are documented. Medication management policies reflect legislative requirements and guidelines. Medicines are safely

managed, stored, and administered by staff with current medication administration competencies. All medications are reviewed by the general practitioner (GP) every three months or when required. The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. The food service is provided onsite and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. A food control plan and Dietitian menu review were in place.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service is a well-maintained home-like setting with all residents having individual bedrooms decorated with personal belongings. All rooms had adequate natural light, ventilation, and heating. The facility meets the needs of aged residents requiring rest home, hospital, and respite care level of care.

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness which expires on 16 June 2021. All rooms are single occupancy, spacious enough to accommodate dependent residents needing assistance, and have en suite toilets and showers. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system.

Appropriate training, information, and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

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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Waratah home and hospital has implemented policies and procedures that support the minimization of restraint. Four restraints were in use. A comprehensive assessment, approval, and monitoring process with regular reviews occurs. No enablers were in use at the time of the audit. The use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control program is appropriate for the size, complexity and degree of risk associated with the service. The infection control Nurse is responsible for coordinating, educating, and training staff. There are infection control policies and guidelines to guide the practice. Infection data is collated monthly, analysed, and reported during staff meetings. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs.

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	49	0	0	1	0	0
Criteria	0	100	0	0	1	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>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and the annual in-service education programme. Residents' rights are upheld by staff. For example, staff knocking on residents' doors before entering their rooms, staff speak to residents with respect and dignity, with staff calling residents by their preferred names. Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents. The last training on the Code was conducted on 28 May 2020 and the next one is planned for 03 June 2021.</p> <p>The residents interviewed confirmed that they are treated with respect and understand their rights. The family/whānau reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent are defined and documented, as relevant, in the resident's record. Some residents had activated EPOA in place and this was sighted in residents' records reviewed. Staff were observed to gain consent for day-to-day care.</p>

they need to make informed choices and give informed 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>The service facilitates the right of residents to advocacy. During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service, with the advocate visiting the service to provide information to residents/families and staff. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Residents and family/whānau were aware of the Advocacy Service, how to access this, and their right to have support persons when required.</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 and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Family/whānau or friends are encouraged to visit or call.</p> <p>The facility has unrestricted visiting hours unless restrictions are required due to either an outbreak at the facility or any current Covid-19 pandemic national lockdown alert levels. Residents reported they can either visit their family in the community or get them to visit them anytime they want. Family members interviewed stated they felt welcome when they visited and are comfortable in their encounters 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>	FA	<p>The service has a complaints management policy and procedures in place that align with the Right 10 of the Code. The services complaint register is detailed regarding dates, timeframes, complaints, and actions taken. All complaints sighted in the register had been investigated and resolved amicably. There were no complaints in 2020 and 2021 had only one recorded. Complaints information is used to improve services as appropriate. Quality improvements or trends identified are reported to the staff. Residents and family are advised of the complaints process on entry to the service. This includes written information about making complaints. Residents and family members interviewed described a process of making complaints that includes being able to raise these when needed or directly approaching staff or the facility manager.</p>
<p>Standard 1.1.2: Consumer Rights During Service</p>	FA	<p>The documented policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their family/whānau, as confirmed by an interview with the quality</p>

<p>Delivery</p> <p>Consumers are informed of their rights.</p>		<p>systems/auditor monitor. Discussions relating to residents' rights and responsibilities take place formally in staff meetings and training forums and informally during daily care delivery. Education is held by the Nationwide Health and Disability Advocacy Service annually.</p> <p>Resident agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements Residents are addressed in a respectful manner and by their preferred names as was confirmed in the interview with residents.</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>	FA	<p>There is a policy and procedure regarding resident safety, neglect, and abuse prevention. Staff respect and allow residents to express their personal, gender, sexual, cultural, religious, and spiritual identity. This includes definitions, signs and symptoms, and reporting requirements. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice.</p> <p>Residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with residents assessed as either respite, rest home, hospital level of care, or needing day care services. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values, and beliefs had been identified, documented, and incorporated into their care plan.</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>	FA	<p>The policy on Māori values and beliefs includes guidance for staff on the provision of culturally appropriate care to residents who identify as Maori. A commitment to the Treaty of Waitangi is included. Family/whānau input and involvement in service delivery/decision making is sought if applicable.</p> <p>Some residents identified as Māori on the audit days. Specific cultural requirements were identified in the reviewed file of a resident who identifies as Maori, and a Maori health plan was included. Staff education is conducted on the Treaty of Waitangi and staff interviewed reported an understanding of their obligations under the Treaty of Waitangi and respect residents' cultural values and beliefs.</p>
<p>Standard 1.1.6: Recognition And</p>	FA	<p>All cultural needs are identified on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner per protocols/guidelines as recognised by the resident</p>

<p>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>		<p>and family/whānau. The service has residents and staff of different cultural backgrounds. Values and beliefs are discussed and incorporated into the care plan. Family members and residents confirmed they were encouraged to be involved in the development of long-term care plans. Residents' personal preferences and special needs were included in the care plans reviewed.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The employment position description and the Code of Rights define residents' rights relating to discrimination. Staff interviewed verbalised that they would report any inappropriate behaviour to the facility manager, clinical manager, assistant clinical manager, or registered nurses (RNs). The quality systems/auditor monitor reported that the facility manager would take formal action as part of the disciplinary procedure if there was an employee breach of conduct. There was no evidence of any behaviour that required reporting and interviews with residents and family/whānau indicated no concerns.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services, and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician, and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and was responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their professional networks to support contemporary good practice. There is specific training and education to assist the staff to manage residents safely. Training is either completed online or face to face at the service or external. The care staff have either level two, three, or four Careerforce qualifications. The activities programme evidenced good practice for residents assessed as requiring rest home, hospital, respite level of care, or day care services.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	<p>FA</p>	<p>The Waratah retirement home provides an environment that is conducive to effective communication. Residents and family 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 or urgent medical reviews. This was supported in residents' records reviewed and in interviews conducted. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>Staff knew how to access interpreter services, these include interpreters from the local district health board, family members, and staff members who can use basic sign language including communication cards.</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 service's strategic business, quality risk, and management plan include the scope, direction, goals, values, and mission statement of the organisation. The strategic business, quality risk, and management plan are current. All these are reviewed annually. The owner/manager reported that the service was certified for 58 dual-purpose beds.</p> <p>The sighted documents describe annual and long-term objectives and the associated operational plans of the business. The owner/manager and the other co-owner have regular formal and informal meetings. Monthly reports showed adequate information to monitor performance is reported including potential risks, contracts, human resources and staffing, growth and development, maintenance, quality management, and financial performance.</p> <p>The owner/manager who is the FM is supported by the CM, ACM, administrator and quality systems/auditor monitor. The other co-owner manages the general maintenance of the building and the procurement process. The management team meets monthly where regular updates are reported to the FM by the clinical team and quality systems/auditor monitor. All members of the management team are suitably qualified and maintain professional qualifications in management and clinical skills. The FM and CM have vast experience and knowledge in the health sector and have been managing the facility for the past 28 years. Responsibilities and accountabilities are defined in a job description and individual employment agreements. The owner/manager interviewed reported that they were currently constructing a new staff car park to ease congestion on the current one.</p> <p>The service holds contracts with the district health board (DHB), ministry of health (MOH) for the provision of rest home, hospital, and respite care. There were 52 residents receiving services on the days of the audit. At the time of the audit, there were (20) hospital geriatric and medical level care residents, (32) rest home level, and respite care (Nil).</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</p>	<p>FA</p>	<p>When the FM is absent, the CM allocated to the role carries out all the required duties under delegated authority with support from the administrator other co-owner. During absences of key clinical staff, the clinical management is overseen by the assistant clinical manager who is an experienced registered nurse in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>

<p>which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<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>FA</p>	<p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement and this is managed by the quality systems/auditor monitor. This includes management of incidents and complaints, internal and external audit programme, staff and family/resident satisfaction surveys, monitoring of outcomes, clinical incidents, and accidents including infection surveillance.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team, staff, health, and safety meetings. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions were developed and implemented to address any shortfalls. Staff, resident, and family satisfaction surveys are completed yearly, and outcomes were positive, and any areas identified needing corrective actions were addressed.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool process. Policies are based on best practices and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. These are managed by the service and an external consultant is sought when required.</p> <p>The quality systems/auditor monitor described the process for the identification, monitoring, review, and reporting of risks and development of mitigation strategies. The quality systems/auditor monitor, and owner/manager are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.</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</p>	<p>FA</p>	<p>There are documented policies and procedures on adverse event reporting. Staff document adverse and near-miss events on an accident/incident paper form and the electronic record management system. A sample of incident forms reviewed showed these were fully completed, incidents were being consistently investigated, action plans developed, and actions followed up in a timely manner. There is an open disclosure policy in place. Family/whānau were notified of any incidents promptly. In the interview conducted the general practitioner (GP) confirmed being notified following adverse events and if there is any change in the resident's condition and this is recorded in residents' records. Neurological observations are completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed, and reported to the management, respectively.</p> <p>The CM described essential notification reporting requirements, including pressure injuries, police attending the</p>

to affected consumers and where appropriate their family/whānau of choice in an open manner.		facility, unexpected deaths, critical incidents, infectious disease outbreaks, and missing persons. They advised there have been no notifications of significant events made to the MOH since the previous audit.
<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>	FA	<p>The nine staff files sampled showed appropriate employment practices and documentation was completed. Current annual practicing certificates are kept on file. Police checks are undertaken. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Four RNs are interRAI trained and competency assessments were sighted in files sampled. The orientation/induction package provides information and skills around working with residents with rest home and hospital and respite level care needs. Staff reported that they receive ongoing training to meet and manage the needs of the residents. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal. Staff training schedule for 2020 and 2021 was sighted and individual training records were maintained.</p> <p>Residents and family interviewed stated that staff are knowledgeable and skilled.</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>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe delivery, 24 hours a day, seven days a week. The service adjusts staffing levels to meet the changing needs of residents. An after-hours on-call roster is in place, with staff reporting that good access to advice is available when required. Care staff reported there were adequate staff available to complete the work allocated to them. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All shifts have a staff member on duty with a current first-aid certificate.</p> <p>There is an activities coordinator who covers the week from Monday to Friday. A designated van driver takes the residents on outings in the community five days a week. The contracted maintenance person works four (4) hours from Monday to Friday and is available on call 24/7. An administrator is available Monday to Friday and is on call as required for any rostering issues.</p> <p>The kitchen staff consists of a head cook who works Monday to Friday and a weekend cook. Kitchen assistants are available. Tea cooks cover the evenings. Housekeeping is managed by housekeepers. There is a registered nurse on 24/7 to cover this facility.</p>
Standard 1.2.9: Consumer Information	FA	The residents' files reviewed identify that information is managed in an accurate and timely manner. The resident's name, date of birth, and National Health Index (NHI) number are used as the unique identifier on all

<p>Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>residents' information sighted. 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. These are entered into the electronic record management system. The interRAI assessment information is entered in the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived paper 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>	FA	<p>The admission to the services managed by the Clinical Manager (CM) and RNs, the required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) agency. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. All resident files reviewed had the appropriate needs assessments prior to admission to the service. Screening processes are communicated to the family/whanau of choice where appropriate, local communities, and referral agencies. The enduring power of attorney (EPOA) of each resident was in place in files sampled. Admission agreements reflect all the contractual requirements. Families and residents reported that the admission agreements were discussed with them in detail in a compassionate and timely manner.</p>
<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>There is a documented process for the management of transfers and discharges. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident. All referrals are recorded in the progress notes. Residents and family/whanau are supported to access or seek a referral to other health and/or disability service providers when required or if the need for other non-urgent services is indicated or requested, Family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the CM and the GP. Acute or urgent referrals are attended to and the resident transferred to the public hospital in an ambulance if required. The service utilizes a standard referral form when referring residents to other service providers, the resident and the family are kept informed of the referral process. Residents and their families are involved in all transition, exit, or discharges to and from the service confirmed by the families during the interview. Verified by documentation and interviews.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p>	PA Moderate	<p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. The service uses an electronic medication chart. Allergies are indicated, and photos current for easy identification. GP conducts three monthly reviews of medication charts sighted in all sample charts. All</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>medication packs are checked by the RN on delivery against medication charts every month. Medicines held in stock are checked every month and any expired medicines are returned to the pharmacy promptly. Medications are stored securely in the trolley and locked cupboards. Annual medication competency is completed for all staff administering medications and medication training records were sighted. A registered nurse was observed administering medicines and complying with required medication protocol guidelines and legislative requirements. One resident was self-administering medications Appropriate processes were in place to ensure this was managed safely, the process complies with medications guidelines as per observation, records sighted and resident interview The CM reported there is no medication error since 2018. A process is in place if there is medication error.</p> <p>Weekly and six-monthly controlled drug stock takes are conducted, monitoring of medication fridge temperatures and medication storage room is conducted, and records were sighted. The service does not store any vaccines onsite.</p> <p>An improvement is required to ensure (i) the nursing team uses medication signing sheet prepared by the pharmacy until medication is charted in the medication electronic system by the GP. (ii) All outcomes of PRN medicines are documented for effectiveness (iii) All used eye drops have open and expired dates on the bottles when opened.</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 service is managed by Chef /head cook, assisted by other two cooks/assistant, and kitchen staff; the service is covered 7 days a week. The cook responsible oversees the procurement of food and management of the kitchen. Meal services are prepared on-site and served in the allocated dining room and residents' rooms as required. The kitchen is adequately equipped. Special equipment such as lipped plates are available. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Checking of fridge and freezer temperature and kitchen inspection is done and records were sighted. The menu has been reviewed by a dietitian. Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents.</p> <p>The nutritional needs are provided in line with recognized nutritional guidelines appropriate to the residents. Additional snacks are provided to residents as needed. The resident's nutritional information is developed on admission which identifies dietary requirements, likes, and dislikes and is reviewed as needed. Supplements are provided to residents with identified weight loss issues. The cook reported feedback is taken from residents on satisfaction surveys and during meetings with residents and on a one-to-one basis. Evidence of resident satisfaction with meals was verified by resident and family interviews, and auditor observation. Residents were given time to eat their meal in an unhurried approach and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed. Dietitian review of menu and dietitian monitoring and audit report within the last two years.</p> <p>The kitchen was registered under the food control plan. Certificate of kitchen audit by relevant authority valid.</p>

		Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges, and freezers temperatures are maintained. Regular cleaning is conducted. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines.
<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	When a consumer's entry to the service is declined, the resident/whanau are referred to the referred agency to ensure that the resident is admitted to the appropriate level of care provider. The reason for declining entry is communicated to the referrer, consumer, and their family or advocate. Assistance is given to provide the consumer and their family or residential services leader with other options for alternative health care arrangements. The CM reported immediate risk identified and managed and decline occurs only in the case prospective resident does not meet the entry criteria or there is no vacancy in the facility.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Residents have their level of care identified through needs assessment by the assessment agency. Initial nursing assessments are completed within the required time frame on admission while residents' care plans and interRAI assessments are completed within three weeks as per the sample file sighted. Assessments and care plans were detailed and included input from the family/whanau, residents, Geriatric Nurse specialist, and other health team members as appropriate. Additional assessments are completed according to the need and these included pains, behaviour, falls risk, nutritional requirements, continence, skin, and pressure injury assessments. The dietary requirements support resident preferences and choices of food, the activities coordinator completes resident activities plan include resident activity selection and preferences. The nursing staff utilized standardized risk assessment tools on admission. The information gathered is documented and informs the planning process. This takes place in the privacy of the resident's bedroom with the resident and/or family/whanau present where possible. A medical assessment is undertaken within 1- 3 days of admission and reviewed as a resident's condition changes, or three monthly as evident by the resident medical record. In interviews conducted, family/whanau and residents expressed satisfaction with the assessment process.
Standard 1.3.5:	FA	Long-term and short-term care plans are developed for acute and long-term needs. Care plans are resident-focused, goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes

<p>Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>identified during the assessment process. Assessments were completed in a timely manner, the interRAI assessment process informs the development of the care plan. The residents and family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care. Staff interviewed reported they found the care plan helpful and guide the residents' care, the verbal and written handover that occurs at the beginning of each shift promotes continuity in care delivery.</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>The documented Interventions in the long-term care plans and Short care plans are adequate to address the resident assessed needs and desired outcomes /goals. The care and interventions are regularly evaluated to ensure set goals are achieved. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted and records sighted. Wound-specific care plan and monthly observations are completed and are up to date including weight, blood pressure monitoring, and blood glucose monitoring. Behaviour management plans are developed with multi-disciplinary input and describe types of behaviour, possible triggers, and interventions. The CM and the GP initiate any specialist referrals to required health services. A range of equipment and resources were available, suited to the level of care provided and following the residents' needs. Staff confirmed they have access to the supplies and products they needed. There is adequate PPE in place. EPOA /Families interviewed were satisfied with the information provided about the support available to residents in the community and confirmed care delivery and support by staff is consistent with their expectations, they were kept informed of any changes to the resident's health status. Resident files sampled recorded communication with EPOA/ family.</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>There is a full range of planned activities that are available on the weekly program for residents to participate in. All residents are assessed and invited to participate in specific activities that are appropriate for their level of ability and interests. The activities are used to facilitate emotional and physical wellbeing. The activities can either be individual or group activities conducted under the guidance of the activities coordinato., Two caregivers provide activities on the weekend as planned and directed by the Activities coordinator. The weekly program is kept in all areas and each resident is given a copy of the program. Families/ Whanau input taken in activities planning and provided a copy of the activities schedule.</p> <p>Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to resident's needs: These include exercises, entertainments, and music played by groups from the community, walking groups, Bus trips, animals visiting activity as appropriate, bingo, watching movies and others as mentioned in the program. Residents and family members interviewed expressed satisfaction with the activities program in place. The auditor had a chance to observe the residents participating in one of the activities. There were evaluations on the residents' participation and the outcomes that residents are</p>

		<p>achieving from these.</p> <p>The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. Maori residents participate in the planned activities as per their choice and preferences, include Maori music, watching a Maori TV channel, and family/Whanau social activities, as confirmed by the CM and Maori resident/family interview.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' long-term care plans, interRAI assessments, and activity plans are evaluated at least every six months and updated in a timely manner when there are any changes. Family/whanau, residents, and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short-term care plans and wound care plans are developed when needed, signed, and closed out when the short-term problem has been resolved. Activities care plan are in place and current. The multidisciplinary review includes CM, CM assistant, GP, and family/EPOA representative if they wish to attend, are conducted 3 monthly and if required. Pharmacist and allied health input is taken as relevant to the resident condition. In interviews conducted, the family members reported that they are kept informed of any changes identified in the care plan process.</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>	FA	<p>There is a documented process for the management of all referrals. The service utilizes a standard referral form when referring residents to other service providers. The CM confirmed that processes are in place to ensure that all referrals are followed up accordingly. Family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the CM /ACM and the GP.</p> <p>Residents and family/whanau are supported to access or seek a referral to other health and/or disability service providers when required. If the need for other non-urgent services is indicated or requested, the GP and the CM sends a referral to seek specialist services assistance from the district health board (DHB). Mandatory referrals are sent to the local community health care professionals like the geriatric nurse, district nursing, physiotherapy, occupational therapy, and dietitians. Referrals are followed up regularly by the CM or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to the public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous</p>	FA	<p>Staff follows documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. The contracted maintenance person is responsible for maintenance issues or requirements. Staff responsible for cleaning have completed the required chemical handling</p>

<p>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>training and ensure adequate stock is held onsite. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant staff training. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. A spill kit is available and accessible if needed.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using them.</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 is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Hot water checks are conducted fortnightly, with all readings below the maximum temperature. The testing and tagging of electrical equipment and calibration of biomedical equipment is current as confirmed in documentation reviewed, interviews with owner/director, and observation of the environment.</p> <p>The corridors are wide enough to enable mobility aids and fitted with handrails to encourage independent mobility. Residents' rooms have direct external access to courtyards and garden areas. There are ramps to enable disability access. Residents can walk around freely throughout the facility and grounds which are securely protected. External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents and family/whānau confirmed they know the processes they should follow if any repairs or maintenance are required, any requests are appropriately actioned, and that they are happy with the environment.</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</p>	FA	<p>There are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. All individual resident's rooms have ensuite bathrooms and each ensuite has a basin and vanity cupboard, walk-in shower, and toilet. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Records of hot water temperatures are maintained to ensure that the water remains at a safe and consistent temperature. Visitor and staff toilets are available at the facility.</p>

requirements or receiving assistance with personal hygiene requirements.		
<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>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are 58 single bedrooms with ensuite bathrooms and each ensuite has a basin and vanity cupboard, walk-in shower, and toilet with a toilet and hand basin. Personal privacy is maintained. Rooms are personalised with furnishings, photos, and other personal items displayed. There is room to store mobility aids, hoists, and wheelchairs. The facility has three hoists, a standing, and two sling hoists. Manual handling training is mandatory for all staff. Staff and residents confirmed the adequacy of bedrooms.</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>	FA	<p>Communal areas are available for residents to engage in activities. There are two large and two smaller lounges. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services</p>	FA	<p>Laundry such as bedding, and towels are washed off-site by a contracted provider and personal laundry is washed on-site or by family members if requested. Family/whānau, interviewed expressed satisfaction with the laundry management and that clothes are returned on time. The laundry has a sluice facility and washing machines and driers are of commercial standards that are checked regularly and maintained by a contracted service provider and overseen by maintenance personal. There are designated cleaning personnel who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. A spill kit is available if required. Material data sheets are available in the laundry and the sluice room for staff to access when</p>

<p>appropriate to the setting in which the service is being provided.</p>		<p>required. Cleaning and laundry processes are monitored through regular feedback from staff and family/whānau, an internal audit programme, and corrective actions are acted upon.</p> <p>Care staff demonstrated a sound knowledge of the laundry processes. There is a clear separation of clean and dirty areas in the laundry.</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 are displayed and known to staff. Disaster and civil defence planning guides direct the facility in the preparation for disasters. These describe procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service. The most recent fire drill was conducted on 08 April 2021. The orientation programme includes fire and evacuation. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, and portable gas cooker, were sighted and meet the requirements for the 52 residents at the service. Evening and night-time security checks are managed by the staff. The electrical equipment safety test log sighted was current. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system audits are completed regularly, and residents and families reported staff respond promptly to call bells.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>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. There are electric heaters in all service areas and each resident's room. Guards are provided around the heaters in the small lounges to promote safety. Rooms have natural light, opening external windows and some have doors that open onto the outside garden or small patio areas. One small lounge is glassed in as a sunroom and is enjoyed by the residents and family/whānau. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed</p>	<p>FA</p>	<p>Waratah Home and hospital service has implemented an infection prevention and control (IPC) program to minimize the risk of infection to residents, staff, and visitors. The program is guided by a comprehensive and current infection control manual, with input from specialist services. The infection control program and manual are reviewed annually. The Infection control nurse is the designated infection control Nurse/coordinator whose role</p>

<p>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>		<p>and responsibilities are defined in a job description. Infection control data, including current infections, antibiotic use, surveillance results, are reported monthly to the CM and tabled at the quality improvement committee meeting. Educational materials displayed around the facility, hand washing posters kept in resident staff and visitors' toilets. The infection control nurse reported the facility requesting anyone who is or has been unwell in the past 48 hours with an infectious condition, 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. Residents and staff were offered the influenza vaccine at the facility through the GPs. The service planned for Covid vaccine through DHB in a week's time.</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>	<p>FA</p>	<p>The infection program is appropriate for the size and complexity of the organization. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated, records and charts sighted. New infections and any required management plans are discussed at handover, to ensure early interventions occur. Handover session observed. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, respectively. The surveillance program is reviewed during the infection control program review. Additional support and information are accessed from the online resources, infection control team at the local DHB, the community laboratory, the GP, and as required. The ICN/ coordinator has access to residents' records and lab results to ensure timely treatment and resolution of any infections.</p> <p>Covid-19 precautions management plan and protective guidelines were in place .Adequate PPE was in place .The covid-19 infection control measures and monitoring information was posted in the facility, including contact tracing guidelines. There is a notice at the main entrance to the facility requesting anyone who is or has been unwell in the past 48 hours with an infectious condition, not to enter the facility.</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</p>	<p>FA</p>	<p>Waratah Infection control 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 organization. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>

are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Staff education on infection prevention and control is conducted by the IC Nurse and online education resources. The ICN/coordinator completed infection prevention and control online to keep knowledge current. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets current best practices and guidelines. External contact resources included the GP, laboratories, and local district health board specialist nurse. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice, there is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.</p> <p>Covid-19 orientation and education for staff was completed. Staff interviewed demonstrated an understanding of the Covid 19 precautions, protective practices of hand-hygiene, physical distancing, isolation and importance of PPE use. Covid-19 educational posters for families and visitors were posted around the facility. Education with residents is generally on a one-to-one basis and has included reminders about handwashing .</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>A surveillance program has been implemented and documented. Infection surveillance practice, activities, and outcomes are well documented and supported with evidence of compliance sighted. Recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported in a timely manner. The ICN and CM oversee the program and staff are informed of surveillance outcomes. Graphs and charts used to present results and benchmarking done through comparison with the previous period. An infection report is completed, and infections are signed off when resolved. Antibiotic usage is monitored and documented through infection reports. The infection register was sighted and is completed monthly. Hand washing audits are completed annually. An infection control annual report was completed. There were no infection outbreaks reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	FA	<p>Waratah Home and Hospital commits to provide quality services for residents in a safe environment and work to minimize the use of restraint. The clinical manager/restraint coordinator provides support and oversight for enabler and restraint management in the facility. On the day of the audit, no enablers were in use at the time of the audit.</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>Use of enablers is voluntary for the safety of residents in response to individual requests. Four restraints were in use as bedside rails. A comprehensive assessment, approval, and monitoring process with regular reviews occurs.</p> <p>Restraint is part of orientation and training is provided annually or as necessary. Approved restraint includes bed rails, lab belts. The staff interviewed were clear regarding the difference between restraint and enabler use. There were four residents on restraints, reviewed by the GP and physiotherapist before utilization as per the Clinical manager and sample records sighted.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>Service policies and procedures meet the requirements of the restraint minimization and safe practice standards and guide the safe use of both restraints and enablers at Waratah home and hospital. The restraint coordinator /CM provides support and oversight for enabler and restraint management and demonstrated a sound understanding of the organization's policies, procedures, practice, and her role and responsibilities. A restraint register is maintained, updated every month, and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using restraint and enough information to provide an auditable record. staff are aware enabler must be the least restrictive and used voluntarily at a resident's request. The restraint can be used as a last resort when all alternatives have been explored and that this would trigger a referral for assessment. The restraint in use (bed rails) have been approved by the clinical team / restraint minimization team. The bed rails restraint used only when the residents in bed, all other time no restraint used. The bed rails are used for the safety of residents due to frequent falls as described by the Restraint Coordinator/CM. The assessment forms have been completed, approvals taken from the clinical team and quality committee. The clinical manager/ restraint coordinator, RN, GP signed on the restraint in use as evidenced by the records sighted. EPOA has signed consent for restraint use. Staff interviewed showed good understanding of restraint and enabler use, and care of resident with restraint. Restraint use is part of orientation and training is provided annually, and regularly as necessary.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The restraint coordinator described that restraint can be used as a last resort when all alternatives have been explored and that this would trigger a referral for assessment. The GP reviewed the restraint use and documented it in the medication chart. Assessment is conducted before restraint use to include any potential risks, falls risk assessment, and behavioural challenges, nutritional and alternative interventions documented. The assessment forms have been completed in the sample of resident records reviewed. Monitoring of resident with restraint completed by the care staff. Restraint is part of orientation and training is provided annually or as necessary. Staff orientation and training on de-escalation intervention and behavioural challenges management is provided annually. Staff interviewed showed a good understanding of restraint and enabler use and care of residents with restraints.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The service policies and procedures meet the requirements of the restraint minimisation and safe practice standards and guide the safe use of both restraints and enablers. The CM /restraint coordinator has the qualification and training in restraints and enablers use. Staff interviewed are aware that an enabler must be the least restrictive measure and used voluntarily at a resident's request. Restraint is used as a last resort when all alternatives have been explored and that this would trigger a referral for assessment by the coordinator. Restraints in use such as bed rails, lap belts have been approved by the restraint minimisation team. The bed rails are only used when the resident is in bed. The bed rails currently used are for safety reasons such as a resident having frequent falls. A falls assessment, physio assessment, nutritional, behaviour, and risk assessments are also completed as described by the CM/restraint coordinator.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The evaluation process covers all requirements of this standard, including future options to eliminate the use, impact the restraint had on resident, the support provided, safety precautions, and outcomes achieved. Restraint audits were completed, and corrective action plans were implemented where required. A review of residents' files and restraint records showed that the individual use of restraints was reviewed and evaluated during care plan, interRAI reviews, three- and six-monthly restraint evaluations, and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. (behavioural assessment, culturally safe practice, long term care plan include restraint expected goals and interventions)</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The quality improvement committee conducts a three-monthly review of all restraint use which includes all the requirements of this standard. Individual restraint uses and monitoring results are reported in the quality and staff meetings every two months. Restraint records reviewed confirmed this included analysis and evaluation of the amount and type of restraint used in the facility, whether all alternatives to restraint have been considered, and the effectiveness of the restraint in use. Restraint use competency assessments for staff were completed annually, Restraint use internal audits also informed these meetings. Any changes to policies, guidelines, education, training needs, and processes are implemented if indicated, as reported by the restraint coordinator /CM in the interview conducted.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>The medication management system in line with the Medicines Care Guide for Residential Aged Care. Indications for use were noted on ‘as required’ medications, allergies were indicated, and resident photos were current. Administration records were maintained, and drug incident forms were completed in the event of any drug errors. Medication administration and storage comply with required medication protocol guidelines and legislative requirements, reconciliation is conducted by the registered nurses when a resident is transferred back to service. All medicines were reviewed every three months or as and when necessary.</p>	<p>(i) Nurses transcribe medication on facility medication chart, the medication details were handwritten by nurses from discharge summary /discharge prescription and used temporarily by nurses to administer medication, until medication is charted by the GP in the medication electronic system.</p> <p>(ii) not all outcomes of PRN medicines were documented for effectiveness</p> <p>(iii) eye drops used as</p>	<p>(i) Nurses to use medication signing sheet prepared by the pharmacy until medication is charted in the medication electronic system. (ii) All outcomes of PRN medicines to be documented for effectiveness. (iii) all used eye drops to have an open and expired date on the bottle.</p> <p>60 days</p>

			PRN, had no opening dates and expiry dates.	
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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.