

Wairarapa Limited Partnership - Wairarapa Village

Introduction

This report records the results of a Provisional 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 Central Region's Technical Advisory Services 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:	Wairarapa Limited Partnership
Premises audited:	Wairarapa Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 27 October 2021 End date: 28 October 2021
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	57

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.

General overview of the audit

Wairarapa Village is an independent care facility certified to provide rest home, hospital and residential disability care for up to 68 residents. Occupancy on the first day of audit was 57 residents.

This provisional audit was conducted against the relevant Health and Disability standards and the contract with the district health board.

The audit process included a review of policies, procedures and resident and staff files; observations and interviews with residents, staff, management; the general practitioner and the chief executive officer.

The facility manager has been in the role for 12 months and is a registered nurse with an annual practicing certificate and has 20 years aged care experience. The facility manager is supported by an experienced clinical manager who has been in the role for 13 months, and a team of registered nurses and health care assistants. The provisional audit was undertaken to establish how well prepared the prospective provider is to provide a health and disability service.

The prospective owner is a chief executive officer who has been involved in managing and governing aged care services for over 30 years. The prospective owner will continue to implement existing systems, management and staffing for the next 6 to 12 months, allowing for considered planning and alignment with two other facilities within the group.

Residents and family spoke positively about the care provided. Interviews with management and staff confirmed that they are committed to deliver services that meet requirements.

Areas identified as requiring improvement relate to: regulatory notifications; short term care planning; monitoring of wound care; neurological observations and weight loss; medication management; hot water temperatures; fire evacuation plan and the monitoring of restraint.

Consumer rights

Wairarapa Village provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes.

Policies are implemented to support individual rights such as: privacy; dignity; abuse/neglect; culture; values and beliefs; complaints; advocacy; and informed consent.

Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family.

Complaints processes are implemented and managed in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

Organisational management

Wairarapa Village has a documented quality and risk management system that supports continuous improvement in the provision of care and services. The quality and risk performance of the facility is regularly monitored, reported, and evaluated. The facility results are discussed with staff, and with residents if required. Action plans are developed and implemented to address areas identified as requiring improvement, and to mitigate risks.

Meetings are held to discuss quality and risk management processes. Residents' meetings have been held and residents and families are surveyed annually.

Policies and procedures align with requirements and evidence best practice. Document control processes are implemented.

There are human resources policies including: recruitment; job descriptions; selection; orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice.

There is an on-line education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after the resident's admission.

The interRAI assessments are used to identify residents' needs and these are completed within the required timeframes. The general practitioner completes a medical assessment on admission and reviews occur thereafter on a regular basis.

Long term care plans are developed and implemented within the required timeframes. Evaluations are completed at least six-monthly. Residents and their relatives are notified regarding any changes in a resident's health status.

Handovers between shifts guide continuity of care and teamwork is encouraged.

An electronic medication management system is in place. Medications are administered by the registered nurse and health care assistants who have completed current medication competency requirements.

The activity programme is managed by diversional therapists. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The service uses its facility van for outings in the community.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a food control plan which is current and displayed. Kitchen staff have food safety qualifications. The kitchen was clean and meets food safety standards. Residents and family confirmed satisfaction with meals provided.

Safe and appropriate environment

There is a current building warrant of fitness. Waste and hazardous substances are managed safely. Staff use protective equipment and clothing where required.

A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes equipment and electrical checks.

Residents' rooms provide single accommodation and are an appropriate size to allow for care to be provided, and for the safe use and manoeuvring of mobility aids. Bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has a monitored call bell system for residents to summon help, when needed, in a timely manner.

Cleaning and laundry services, are provided seven days a week by household staff, and are monitored.

There are sufficient communal areas within the rest home and hospital areas that include lounge and dining areas. An external courtyard area is accessible for residents using mobility aids and external gardens are accessible with suitable pathways and shade areas.

The service has implemented policies and procedures for civil defence and other emergencies, and six-monthly fire drills are conducted. Essential security systems are in place to ensure resident safety. An appropriate newly updated call bell system is available for residents in all locations of the facility to access help in a timely manner.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse. On the day of the on-site audit, there were eight residents using restraints and two residents using enablers. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary.

Infection prevention and control

The infection control programme is appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed, and trended. Monthly surveillance data is reported to staff. There have been no outbreaks since the previous audit.

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	43	0	4	3	0	0
Criteria	0	94	0	4	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

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>Wairarapa Village has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed on the day of audit were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with residents and family members.</p> <p>The chief executive officer (CEO) of the company purchasing the service, interview described extensive training in the Code.</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>Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement and additional consents are signed by the resident or their enduring power of attorney (EPOA). The admission agreements have been signed on admission in the sample of files reviewed.</p> <p>Advanced directives sighted in the resident files were signed</p>

		appropriately. The health care assistants and the registered nurses (RNs) confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.
<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 are provided with a copy of the Code pamphlet on admission. Interviews with residents and family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. An advocate meets monthly at resident meetings (minutes sighted).</p> <p>Residents confirm that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the residents' family and chosen social networks.</p> <p>The facility manager (FM) described links with the local advocate and is able to invite them in if needed.</p> <p>The CEO of the company purchasing the service described knowledge of advocacy services and how they would be able to support residents if 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>Interview with residents confirm that relatives and friends can visit at any time and are encouraged to be involved with the service and care (dependent on Covid-19 restrictions). Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs, and interest groups in the community. Residents confirm the staff help them access community groups.</p> <p>The managers and staff actively engaged with family on behalf of residents during the Covid-19 lockdown period and they also support residents to engage with their family members through zoom and email.</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>	<p>FA</p>	<p>There is an implemented complaints policy and procedure that complies with Right 10 of the Code and includes timeframes for responding to the complainant.</p> <p>An up-to-date complaints register is in place. The register includes: the date the complaint is received and acknowledged; the source of the complaint; a description of the complaint; the investigation; changes implemented and the date the complaint is resolved.</p> <p>Complaint forms are easily accessible throughout the facility.</p> <p>There had been three written and one verbal complaints, since the previous audit. Complaints reviewed indicated that they are investigated promptly, and issues are resolved in a timely manner.</p> <p>The FM is responsible for managing complaints. Residents and family interviews confirmed that they were aware of a complaints process and would feel comfortable to make a complaint if needed. They confirmed that issues raised are dealt with effectively and efficiently.</p> <p>Minutes of the resident's meetings outline that complaints or concerns are raised in this forum alongside reminders regarding the process of how to make a complaint.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner or other external agencies since the previous audit. A complaint at the previous audit lodged with the Wairarapa DHB has been signed off by the DHB and recorded as completed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>A welcome pack provided to residents on entry to the service, includes: information on how to make a complaint, Code of Rights pamphlet, advocacy, and Health & Disability Commission (HDC) information.</p> <p>Relatives and residents are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement and in the welcome pack provided to residents and family when they enquire about services. Residents and family members interviewed confirmed they received all the relevant</p>

		information during admission.
<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>Wairarapa Village has a philosophy that ensures the residents' rights to privacy and dignity are always recognised and respected. Residents are encouraged to maintain their independence. Outings are encouraged and supported for the residents who are able. Staff interviewed stated that they encourage the residents' independence by encouraging them to be as active as possible.</p> <p>During the audit, health care assistants were sighted knocking on resident's bedroom doors prior to entering and ensure doors are shut when cares are being given. Resident and relative interviews confirmed that privacy is being respected.</p> <p>Resident files reviewed identified that cultural and/or spiritual values and individual preferences were identified on admission with family involvement and these were documented in the residents' care plans. This includes cultural, religious, social, and ethnic needs. There are clear instructions provided to residents on entry and in their admission agreement, regarding responsibilities of personal belongings.</p> <p>Interviews with the clinical manager (CM), staff and young people with disabilities (YPDs) confirmed that they are supported to access services that are meaningful to them. As an example, YPDs have access to a massage service, one on one entertainment with volunteers, or special food and drinks as well as the use of an electronic program to assist with communication.</p> <p>The relatives interviewed stated their family was welcomed into the home. Personal pictures were put up to assist residents to orientate to their new environment. Interviews with the health care assistants described how choice is incorporated into resident cares.</p> <p>There is an abuse and neglect policy that sets out the guidelines to prevent, identify, report any incidences of abuse and neglect. Staff receive orientation and mandatory annual training on abuse and neglect.</p> <p>The CEO of the company purchasing the service was interviewed and demonstrated knowledge around abuse and neglect and the process</p>

		of escalation of issues.
<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>Wairarapa Village has a Māori health plan and a cultural safety policy. Currently there are no residents who identify as Māori. Linkages with Māori community groups are available and accessed as required. The service links with the district health board (DHB) for advice and support if required related to Māori.</p>
<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	<p>There is policy and procedure on cultural responsiveness to ensure that the service consults residents and family on their specific cultural needs, values, and beliefs to guide the delivery of care.</p> <p>Cultural needs, spiritual values, and beliefs were screened and recorded as part of the residents' assessments. Residents' lifestyle and activity plans were documented and implemented to reflect individual preferences. Example of activities on offer included church services and pet therapy.</p> <p>Interviews with staff, residents and family evidenced that residents are provided with choices regarding their care, and that services provided meet their cultural and spiritual needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff describe implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment, and exploitation. Training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed state that they were aware of the policies and were active in identifying any issues that relate to the policy.</p> <p>Job descriptions include responsibilities of the position. Signed copies of all employment documents, including job descriptions, were sighted in the staff files sampled. Staff comply with confidentiality and the code of conduct.</p> <p>The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff</p>

		<p>confirmed their understanding of professional boundaries, including the boundaries of the health care assistant's role and responsibilities.</p> <p>Residents and family interviewed confirmed that they would formally complain to management if they felt that they were discriminated against.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The facility implements policies and procedures that are current and based on good practice and current legislation and guidelines. Policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice.</p> <p>The annual training programme provided to all staff includes: the implementation of policy and procedures, good practice and service delivery.</p> <p>Clinical consultation and expertise are available through DHB and hospice clinical leadership.</p> <p>Staff and resident interviews, progress notes in residents' file notes and observation of service delivery confirmed that resident care was based on good practice guidelines</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure, including for residents who do not have any family to notify. Relatives stated they are notified promptly of any incidents/accidents. There is documented evidence the family had been notified promptly of accidents/incidents.</p> <p>Families receive newsletters that keep them informed on facility matters and events. Resident meetings encourage open discussion around the services provided (meeting minutes sighted).</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The information is given to a potential resident and family by the need's assessment service, as well as by the service at the time of enquiry and when entering the service.</p>

		<p>There is access to an interpreter service as required.</p> <p>During the lockdown period of the Covid-19 pandemic, there was evidence that the service had connected with residents and family through zoom and through emails. Residents were kept informed.</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>Wairarapa Village is a privately-owned rest home and hospital attached to a retirement village (i.e. independent living service apartments and villas). The organisation has a vision and mission in place, which are resident centred and value independence, respect and community. The organisation values were displayed in the entrance to the building, and they are shared with residents, family, and staff during orientation to the service, as confirmed in interviews.</p> <p>Wairarapa Village director is responsible for the organisational governance. A documented business plan includes objectives that relate to the quality of service delivery, business continuity, performance and risks. The business plan has a balanced score card with organisational goals, measures and an action plan that includes key service indicators relevant to all residents, including YPDs.</p> <p>The transitional plan is that the village director will continue in this role (a partner in the new company) for 6 to 12 months to assist with the transition. The FM interviewed reports to the village director on key performance indicators that cover: clinical services; occupancy; service administration; complaints; incidents; and notifications. The FM explained they participated in weekly meetings with the village director.</p> <p>The FM has been in the role for 12 months, has long-term management experience in aged care facilities, and experience in community nursing. The CM returned to this role after a break to manage another aged care facility and has been in this position for 13 months. The FM and CM have current RN practicing certificates. The team is supported by RNs on-site and an off-site human resources consultant.</p> <p>The service is certified to provide hospital, rest home, and residential disability-physical care for up to 68 residents. This includes</p>

		<p>certification for 11 hospital beds, 9 rest home only beds, (eight of which are Occupational Rights Agreement (ORA) rest home approved serviced rooms within the facility) and 48 dual-purpose beds. There was a total of 57 residents in the facility on the first day of audit: 24 receiving hospital care and 32 receiving rest home care and one rest home resident in the ORA room. Numbers include five YPDs: three with physical disabilities assessed at hospital level care; two with physical disability assessed at rest home level care; and one with intellectual disability assessed at rest home level care. The facility also has included in these numbers, two rest home residents, (one on respite care) and one hospital resident under accident compensation corporate scheme (ACC) agreements.</p> <p>Current contracts with the DHB were sighted and covered aged-related residential care (ARRC); short-term residential care; long-term conditions; health recovery programme; and residential non-aged care.</p> <p>The prospective owner is a chief executive officer who has been involved in managing and governing aged care services for over 30 years. The prospective owner will continue to implement existing systems, management and staffing for the next 6 to 12 months, allowing for considered planning and alignment with two other facilities within the group.</p> <p>The proposed sale of the business is set to proceed in November 2021 or the date of confirmation through the audit. The new owner confirmed that they would work with the village director on-site to provide strategic leadership and operational management overall for the next 6 to 12 months. The business partners intend to take on an operations manager to also support Wairarapa Village as well as their other two facilities.</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 consumers.</p>	<p>FA</p>	<p>Absences of the FM are covered by the CM. The CM is supported by RNs who can step up to cover CM leave, with the assistance of the FM. The FM and CM are on call 24 hours a day, 7 days a week to support the facility with emergency matters.</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>Wairarapa Village has a policy and strategic plan that outline the facility commitment to continuous quality monitoring, improvement, and dissemination amongst staff. Described quality system comprises an audit process; clinical performance indicators; policies/systems staffing/education; annual residents' surveys; complaints review; incidents/accidents and risk management. Meeting minutes reflected commitment to the quality improvement system and its execution.</p> <p>The facility has a document control policy in place. Interview with the FM and observations confirmed that documents were managed as per policy, including the removal of obsolete versions.</p> <p>An internal audit plan is documented and implemented, which enables the key components of service delivery to be monitored and inform organisation planning to improve quality and risk. Corrective action reports (CARS) were initiated in response to quality gaps identified in the service. Management, staff and residents' interviews confirmed those happened in practice.</p> <p>Annual residents' surveys capture residents/family' satisfaction with the service, including YPDs' satisfaction. The FM also demonstrated how feedback is specifically sought from the YPDs through individual meetings. Review of 2020-2021 outcomes highlighted areas of improvement in relation to communication with family and residents' activities. There was documented evidence that the facility had since deployed additional resources to support linkage with family, and a continuous improvement plan around diversional therapy had been started that included a tailored programme delivered to the YPDs, as well as improvement to staffing levels.</p> <p>Data is monitored to measure the quality performance of the services/operations. Review of minutes from regular meetings with management, staff, committees, and residents/family evidenced that data is analysed and evaluated, shared with staff, documented corrective action plans are developed, implemented, evaluated and signed off. There was documented and interview evidence that any subsequent changes to procedures and practices were communicated to staff, and to residents/family if relevant.</p>

		<p>Service outcomes are evaluated against the quality framework and benchmarked against past results, and when able with two other local facilities.</p> <p>A sighted updated risk management (hazard) register inclusive of health and safety risks associated with the environment, service delivery and human resource management are identified, evaluated, and mitigated through implemented processes. Staff complete hazard forms (sighted) to signal environmental and personal risks. Hazards to residents are recorded in electronic format through incidents and accidents which prompt automatic evaluation of risk severity and consequence. Health and safety committee meets monthly to review findings and where required to develop action plans (reviewed minutes).</p> <p>There are no planned changes to the quality, risk management or health and safety systems should the sale be realised.</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>PA Low</p>	<p>The FM and CM are aware of situations for which the service is required to report and notify statutory authorities. The managers advised there had been, no notifications made to the Ministry of Health under section 31. However, not all essential reporting had occurred as required.</p> <p>Staff interviewed were aware of the organisation processes and procedures regarding the reporting, notification and management of adverse events affecting residents.</p> <p>Review of incident/accident electronic records evidenced that staff document adverse events and near misses, and notify the resident, family/EPOA, GP and medical emergency services when necessary. Review of fall events indicated that vital signs and neurological observations were not always completed and documented for un-witnessed falls (refer 1.3.6.1).</p> <p>The CM and FM are responsible for reviewing clinical accidents/incidents and for developing corrective actions that mitigate future risks. Incidents and accidents are included in governance reports and discussed in quality meetings with heads of department</p>

		<p>and RNs to inform quality and risk improvement plans.</p> <p>The new CEO is knowledgeable concerning the legislative and regulatory requirements under the Health and Disability Services (Safety) Act 2001 (The Act) Section 31.</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>	FA	<p>There are human resources policies to support recruitment practices. Staff files sampled contained all relevant employment documentation. Current practising certificates were sighted for the RNs, and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>There is an education planner in place that covers compulsory education requirements over a two-year period. Regular reviews and additions to the programme support practice changes, up skilling of staff, and demands from residents' cares and situations. Education is delivered by the CM, by external providers, through online learning, or by RNs encouraged to take responsibility for a clinical portfolio and to share expertise. Education session attendance records evidenced that ongoing education is undertaken by clinical staff to meet at least eight hours of required training per year.</p> <p>Eight of nine RNs are interRAI trained. Clinical staff complete competencies relevant to their role including medication, and safe manual handling. The infection prevention and control and restraint RNs had job descriptions specific to their roles. Review of sampled staff appraisals showed they occur at least yearly.</p> <p>The new CEO of the service has qualifications relevant to management roles and aged care and confirmed that the service will continue to implement the existing training schedule.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	FA	<p>The roster model used predicts the number of staffing hours and skill mix required to deliver residents' care 24/7, which complies with contractual requirements and considers the need to have at least one</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>staff member available in each area of the facility to cover the complex layout (i.e. five connected parts). The ORAs are incorporated into the existing rest home/dual purpose bed configuration. Current rosters are adjusted according to actual occupancy levels.</p> <p>The FM interviewed devises and implements a documented plan for health care assistant allocation based on: residents' acuity; staffing support in each facility wing; and backup cover for the health care assistant who might assist the retirement village with emergencies. Discussion with the FM confirmed that in village emergencies the health care assistant role is limited to first response and assessment. Registered nurses are not displaced to provide services to the village or serviced apartments.</p> <p>Bed making, cleaning and laundry personnel are available to support health care assistants who can focus on personal cares with residents. Other non-clinical staff rostered seven days a week include activities officers and kitchen employees. There is access to a podiatrist and physiotherapist as required.</p> <p>Sample review of past rosters showed adequate staff cover 24/7. Absent staff are replaced by on-call/casual employees. The FM explained ongoing recruitment of staff to mitigate staffing variances and risks, which was also evident in employment documentation reviewed. The facility has had a turnover of RNs since the last audit with the last vacancy being filled for an experienced RN commencing in November.</p> <p>Staff interviewed reported that pool of staff is stable and there is enough staff to manage the workloads.</p> <p>Residents and family reported adequacy of staff levels and skills to complete the required cares and services in a timely and safe manner.</p> <p>The FM (RN) works Monday to Friday 0830-1700 and is supported by the CM (RN) who works Monday to Friday 0800-16.30.</p> <p>Following input from residents and staff meetings (CARs), as well as being able to employ new staff, the FM has altered the roster from November to increase RN hours to two RNs on morning shift, increasing the morning health care assistants by a 0830-12.30 shift and increasing the afternoon health care assistants 1600-2200 shift to</p>
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		<p>1445-2200 (the 1630-2030 shift will be dropped).</p> <p>The new CEO stated there are no plans to change staffing levels if the service is purchased</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Policies and procedures on resident information privacy and confidentiality are consistent with the requirements of the Privacy Act and Health Information Privacy Code. At interview staff described the procedures for maintaining confidentiality of residents' records. No personal or private resident information visible to the public during the audit. Electronic data is password protected and can only be accessed by designated staff.</p> <p>Residents' records and medication charts are maintained through an electronic system. Residents' progress notes reviewed are completed every shift, detailing response to service provision and progress towards identified goals. An electronic system allows identification of the staff member making the entry. Review of electronic records evidenced that all relevant information is logged or uploaded into the system. InterRAI assessments are completed as required. Resident information can be retrieved in a timely manner.</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>Needs assessment and service coordination (NASC) assessments are completed for patient's entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. There is an information pack provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service processes are implemented, ensuring compliance with entry criteria.</p> <p>Residents and family members interviewed stated they were satisfied with the admission process and that it had been completed in a timely manner. Information about Wairarapa Village had been made available to them. Residents' files reviewed contained completed demographic detail, assessments and signed admission agreements</p>

		in accordance with contractual requirements.
<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>Transition, exit, discharge, or transfer is managed in a planned and coordinated manner.</p> <p>Interviews with RNs and review of residents' files confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers. A transfer form accompanies residents when a patient is moved to another service or facility. Follow-up occurs to check that the resident is settled.</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>	PA Moderate	<p>A current medication management policy identifies all aspects of medicine management in line with relevant legislation and guidelines.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices are in line with legislation, protocols, and guidelines. The required three-monthly reviews by the GP were recorded electronically. However, resident allergies and sensitivities are not consistently documented on the electronic medication chart.</p> <p>The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are standing orders in use, these were reviewed annually and signed off by the GPs.</p> <p>Review of the medication fridge evidenced that the service does not store or hold vaccines and interview with the RN confirmed this. The medication refrigerator temperatures and medication room temperatures are monitored daily.</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks of medications are conducted in line with policy and legislation, however, the six-monthly stocktake has not been</p>

		<p>completed.</p> <p>The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. The RN oversees the use of all pro re nata (PRN) medicines, however, documentation regarding effectiveness of PRN medications administered is inconsistent. Current medication competencies were evident in staff files.</p> <p>There was one resident self-administering medication on the day of the audit. The resident had a current competency assessment, safe storage of their medication within their room and could describe the need and process for these when interviewed. All legal requirements had been met.</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>All meals are prepared on site. The seasonal menu has been reviewed by a dietitian. The food control plan's expiry date is July 2022.</p> <p>The kitchen was observed to be clean. Temperatures of freezer are monitored and recorded daily. Food temperatures are monitored appropriately and recorded. Cleaning schedules and temperature monitoring requirements are organised and recorded using an electronic system. Review of the electronic system confirmed that cleaning schedules and temperature monitoring were completed and current.</p> <p>All kitchen staff have relevant food hygiene and infection control training.</p> <p>A nutritional assessment is undertaken for each resident on admission by a RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident's dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning. Supplements are provided to residents with</p>

		<p>identified weight loss problems as medically required.</p> <p>Residents were seen to be given enough time to eat their meal and assistance was provided when necessary. There were enough staff to ensure appropriate assistance was available. Residents and families interviewed stated that they were satisfied with the meals provided.</p> <p>All aspects of food procurement, production, preparation, storage, delivery, and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and cool store. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated.</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 service has a process in place if access to the service is declined. When residents are declined access to the service, residents and their family/whānau, the referring agency and general practitioner (GP) are informed of the decline to entry. The resident would be declined entry if not within the scope of the service or if a bed was not available.</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>The initial nursing assessments which include dietary needs, pressure injury, falls risk and social history are completed using the electronic system. Assessments reflect data from a range of sources, including: the resident; family/whānau; the GP and specialists.</p> <p>The initial care plan guides care for the first three weeks following admission. Registered nurses complete the interRAI assessment within the required timeframes. The LTCP is based on the interRAI assessment outcomes and the initial nursing assessments.</p> <p>Policies and protocols are in place to ensure continuity of service delivery.</p> <p>All residents under the aged related residential care contract have current interRAI assessments completed by one of eight trained interRAI assessors on site.</p>

		Residents and family members confirmed involvement with the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Long-term care plans are developed from information gathered during the first three weeks following admission and from the interRAI assessment. All residents' files sampled had individualised LTCPs with interventions to meet the needs of the residents. Care plans demonstrate service integration with clinical records, activities notes, and medical and allied health professionals' notes and letters.</p> <p>Activity assessments were completed by the activities staff within three weeks of admission. For YPDs, support plans are person centred, developed with the person and include wellbeing, community participation and meeting physical and health needs.</p> <p>Short-term care plans were evident in some resident files and addressed short term concerns, for example, wandering and post falls management. However, short-term care plans were not in place for the care of all residents with an infection.</p> <p>Interviews with residents confirmed that the care provided met their needs. There was documented evidence that EPOA/family/whānau had been involved in the review 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>	PA Moderate	<p>Long-term care plans are completed by the RN and based on assessed needs, desired outcomes, and goals of residents. Short-term care plans are in place for some acute problems; however, they are not in place for all residents who have an infection (refer to 1.3.5.2).</p> <p>The GP documentation and records reviewed were current. The GP interviewed stated that there was good communication with the service and that they were informed of concerns in a timely manner. An afterhours medical service is provided.</p> <p>The physiotherapist visits the facility weekly and reviews new admissions, residents who have sustained a fall and residents referred by the RNs.</p>

		<p>Staff interviewed confirmed that they are familiar with the needs of residents and that they have access to the equipment, supplies and products they require to meet those needs.</p> <p>There is evidence of wound care products available at the facility. A review of the wound care plans evidenced all wounds had documentation in place. However, the documentation reviewed was not comprehensive and wound care is not carried out in accordance with policy or best practice. Additional specialist input is sought when required for residents with complex wounds.</p> <p>Monthly observations temperature, pulse, blood pressure and weight are recorded on the electronic system, however, they are not consistently recorded in the timeframes required.</p> <p>Neurological observations are recorded following unwitnessed falls, however, the length of time these are recorded is inconsistent and the Wairarapa Village falls policy does not align with best practice.</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 residents' activities programme is implemented by three diversional therapists (DT) and an activities officer. Activities for the residents are provided seven days a week, 0930 to 1500 hours. The activities programme is displayed on a large board in the reception area and on the individual resident noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural, spiritual and community events. Church services are held fortnightly. Van outings into the community are arranged twice a week. A roster system is operated to ensure those residents wishing to go on outings have a regular opportunity to do so.</p> <p>The residents under the YPD contract are included in the activity programme and they confirmed that they were satisfied with activities that were provided. The DT interviewed is in the process of developing additional activities to maintain the family and community links for the five residents under the YPD contract. The planning involves specific meetings for these residents to facilitate targeted individual and group activities. A 'digital club' is held once a week to help residents with cell</p>

		<p>phones, tablets, and other devices.</p> <p>The residents' activities assessments are completed by the DT within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on residents' interests, family and previous occupations is gathered during the interview with the resident and/or their family and documented. The residents' activity needs are reviewed six-monthly at the same time the care plans are reviewed and are part of the formal six-monthly multidisciplinary review process.</p> <p>The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Long-term care plans are evaluated every six months in conjunction with the interRAI re-assessments or if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes.</p> <p>The service develops short-term care plans for the management of some short-term acute problems. If in place short-term care plans are reviewed and signed off when the problem is resolved. However, short-term care plans are not developed for all residents who have an infection (refer to 1.3.5.1).</p> <p>Contact with family/whanau was verified in the resident's records.</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>The service facilitates access to other medical and non-medical services. Where needed, referrals are sent to ensure other health services, including specialist care is provided for the resident. Referral forms and documentation are maintained on resident files. Referrals are regularly followed up. Communication records reviewed in the residents' files confirmed family/whānau are kept informed of the</p>

		referral process.
<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>	FA	<p>The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed. Chemicals were secured in designated locked cupboards. Chemicals were labelled, and safety datasheets were available and accessible to staff. Safe chemical handling training has been provided by the contracted supplier. Gloves, and aprons, are available, and staff were observed wearing personal protective equipment/clothing (PPE) while carrying out their duties. The maintenance person interviewed described the safe management of hazardous material.</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>	PA Low	<p>A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation. A current certificate of public use for the new wing was sighted.</p> <p>A preventative and reactive maintenance schedule is implemented. This includes monthly maintenance checks of all areas and specified equipment such as hoists. Staff identify maintenance issues on an electronic system. This information is reviewed daily, or more frequently, by the maintenance person and attended to as required. Interviews confirmed staff awareness of the processes for maintenance requests and that repairs were conducted in a timely manner.</p> <p>Interviews with staff and visual inspection confirmed there is adequate equipment available to support care. A tour of the environment demonstrated adequacy of the premises and equipment to support cares, which was confirmed by residents, family and staff interviewed.</p> <p>The FM explained that the facility uses the services of an occupational therapist to advise on equipment and resources to purchase for the YPDs (e.g., an electrical wheelchair). The YPDs interviewed confirmed that they had exclusive use of their equipment, which was suitable for</p>

		<p>their needs.</p> <p>The facility has an up to date annual test and tag programme. Evidence of checking and calibration of biomedical equipment, such as hoists was sighted. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained. Inspection confirmed that the van has a current registration, warrant of fitness, first aid kit, and fire extinguisher. Staff interviews, and documentation evidenced that those staff who drive the van have a current driver's licence.</p> <p>Hot water temperatures are assayed monthly. A review of temperature assays and interview with the maintenance person confirmed that if hot water temperatures are found to be above the recommended safe temperature, action is taken by a plumber. However, a boiling water beverage tap is unprotected.</p> <p>All resident areas can be accessed with mobility aides. There are accessible internal and external courtyards and patios. All external garden areas have outdoor seating and shade and can be accessed freely by residents and their visitors</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>All resident rooms throughout the facility are single rooms and provide adequate space for resident cares to be provided as sighted during the audit. In addition, there are communal mobility bathrooms, with showers and toilets of sufficient size for mobility aids. These are located within easy distance of rooms that do not have shared bathrooms. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include vacant/in-use signs. There are easy clean flooring and fixtures, and handrails are appropriately placed.</p> <p>Large rooms are allocated to residents with physical disability needs, including YPDs, to support mobility and assistance. On observation, there is enough space in bed areas to allow staff and residents, including those with a physical disability, to move freely and manoeuvre equipment. Rooms are organised to include a seating area</p>

		<p>for residents and visitors.</p> <p>All wheelchairs and care equipment are stored in dedicated areas which are readily accessible. Electric scooters are powered and parked in outside covered car port.</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>	FA	<p>Residents and their families can personalise the resident's room. Furniture in residents' rooms include residents' own personal pieces and memorabilia; is appropriate to the setting and is arranged in a manner that enables residents to mobilise freely.</p> <p>Large rooms are allocated to residents with physical disability needs, including YPDs, to support mobility and assistance. Rooms are organised to include a seating area for residents and visitors.</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>There are spacious communal areas to meet the recreation needs of the residents. Two large lounges are open space and allow residents to engage in group activities, social entertainment. Quiet alcoves are organised to accommodate private gatherings of residents and family, including the YPDs. Young people with disabilities are provided with large individual rooms to support their needs and to meet in private. An additional family/end of life room is under renovation and a reconfiguration form to HealthCERT is yet to be submitted. Two dining areas offer a table service to residents and promote independence. Furniture is appropriate to the setting and the needs of the residents.</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>	FA	<p>Residents' personal laundry is managed on-site by the laundry person. The linen/slucie laundry is performed off-site by a contractor. Care givers are responsible for the sorting of linen, personal laundry, and infectious items into different coloured bags. The bags are set in trolleys with lid covers.</p> <p>Cleaning and laundry services are continuously monitored through internal audits.</p> <p>Visual inspection of the on-site laundry demonstrated the</p>

		<p>implementation of a clean/dirty process for the hygienic washing, drying and handling of personal clothes. The safe and hygienic collection and transport of laundry items into relevant colour containers was witnessed. Household and laundry personnel interviewed demonstrated knowledge of the process to handle and wash infectious items when required.</p> <p>Residents clothing is labelled and personally delivered from the laundry, as observed. Residents and family/whānau confirmed satisfaction with laundry services in interviews and in satisfaction surveys.</p> <p>Two cleaners are on duty each day, seven days a week and cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. Household personnel interviewed are aware of the requirement to keep their cleaning trolleys in sight. Chemical bottles/cans in storage and in use were noted to be appropriately labelled.</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>PA Low</p>	<p>All staff complete fire emergency and safety training as part of their orientation and annual education (records verified). A sprinkler system was observed throughout the buildings as well as emergency exit signs. Plans on display indicated fire cells for evacuation. Due to changes of internal fire cells as a part of widening corridors a new fire evacuation plan is yet to be approved.</p> <p>Registered nurses on duty act as fire wardens and emergency first responders. Valid first aid certificates were verified for staff who require them. Documented evacuation drills are conducted at least six-monthly.</p> <p>Stores of civil defence emergency supplies were sighted and included blankets, batteries, barbeque, gas, and enough food for three days. Water tanks provide the required amount of fresh water that is replaced at least six-monthly. Continence supplies are in stock to cater for the needs of residents in an emergency. A stock of protective</p>

		<p>equipment is kept on site to cover outbreaks.</p> <p>A documented emergency management plan sets procedures in response to disasters, safety breaches and civil defence emergencies. The plan includes procedures for the evacuation of residents with mobility challenges, such as the YPDs.</p> <p>Call bells are available to summon assistance in all residents' rooms, bathrooms and toilets. Call bells are diverted to pagers carried by clinical staff. The call bell system is centrally wired across the facility, and a new display shows call bell location at the nursing station. The call bell system is audited monthly by the maintenance team to ensure safe functioning. The whole call bell wiring and display network has been checked at recent installation.</p> <p>Surveillance cameras are in place in key communal areas and entrance ways to support the security of residents, staff and visitors. Signage notifies the public of the presence of closed-circuit television (CCTV). After hours, outside gates, doors, and windows are locked. A security company completes rounds of the premises at night.</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 bedrooms and communal areas have ample natural light and ventilation. There is electrical heating throughout the facility. Staff and residents interviewed stated that this is effective. All areas are smoke free. The facility has a designated outdoor covered area for staff and residents who need to smoke or vape.</p>
<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>	<p>FA</p>	<p>Wairarapa Village provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an infection prevention and control programme. A RN is the infection control nurse (ICN) and has completed training for the role. The ICN has access to external specialist advice from the DHB infection control specialists when required. A documented role description for the ICN is in place. The ICN reports to the CM and FM.</p> <p>The infection control programme is appropriate for the size and complexity of the service. The infection prevention and control</p>

		<p>programme is reviewed annually. Staff are made aware of new infections through daily handovers on each shift, progress notes and clinical records. However, short-term care plans are not in place for the care of all residents who develop an infection (refer to 1.3.5.1).</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. Covid-19 education has been provided for all staff, including hand hygiene and use of personal protective equipment.</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>There are adequate resources to implement the infection control programme at Wairarapa Village. The ICN who is responsible for implementing the infection control liaises with the infection control committee who meet three-monthly and as required. The committee is made up of staff from the care centre, laundry, cleaning and kitchen.</p> <p>Infection control reports are discussed at the facility's meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p> <p>External resources and support are available through external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the facility management team.</p> <p>Infection prevention and control resources were available should a resident infection or outbreak occur.</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</p>	FA	<p>Wairarapa Village has documented policies and procedures in place that reflect current best practice relating to infection prevention and control.</p> <p>Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p>

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>The ICN is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff. Staff have completed infection control education in the last 12 months. The ICN has access to an online training system with resources, guidelines, and best practice. The ICN has completed infection control audits.</p> <p>Covid-19 information is available to all visitors to the facility. Ministry of Health information was available on site.</p> <p>Education for residents occurs at the residents' meetings and informally on a one-to-one basis. Topics covered include hand hygiene, Covid-19 information and the requirement to stay in their rooms if they have an infection.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is an integral part of the infection control programme. The purpose and methodology are described in infection prevention and control policy in use at the facility. The ICN uses the information obtained through surveillance to determine infection control activities, resources and education needs within the service.</p> <p>Monthly infection data is collected for all infections based on standard definitions. Infection control data is monitored and evaluated monthly and annually. Trends are identified and analysed, and corrective actions are established where trends are identified. These, along with outcomes and actions, are discussed at the infection control meetings, quality, and staff meetings. Meeting minutes are available to staff.</p> <p>There have been no outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	FA	<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 restraint coordinator is a</p>

<p>minimised.</p>		<p>RN, they provide support and oversight for enabler and restraint management in the facility. The restraint coordinator is conversant with restraint policies and procedures.</p> <p>On the day of the audit, eight residents were using restraints, bedrails, and chair briefs. Two residents were using enablers, a chair brief, and bedrails. A similar process is followed for the use of enablers as is used for any restraint use.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of restraint minimisation. Regular training occurs. Review of restraint and enabler use is completed and discussed at all quality and clinical meetings.</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>The restraint approval process is described in the restraint minimisation policy. The restraint coordinator is a RN with a job description that defines the role and responsibility of the restraint coordinator.</p> <p>An assessment and management process is followed for the use of both restraints and enablers which ensures the ongoing safety and wellbeing of residents. The restraint coordinator was unavailable for interview. The CM explained the process for determining approval, for recording, monitoring, and evaluating any restraints or enablers used. The GP interviewed confirmed involvement with the restraint approval process. Family/whānau approval is gained should any resident be unable to do so, and any impact on family is also considered. This was evidenced by documentation and files viewed.</p> <p>Training for all staff occurs at orientation. Registered nurses and health care assistants are required to complete restraint minimisation training online.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	<p>FA</p>	<p>The restraint/enabler policy details the process for assessment. Assessment covers the need, alternatives attempted, risk, cultural needs, impact on the family, any relevant life events, any advance</p>

undertaken, where indicated, in relation to use of restraint.		directives, expected outcomes and when the restraint will end. Completed assessment templates were sighted evidencing assessment, including consultation with family and GP.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Moderate	<p>Restraint and enablers are only used to maintain resident safety and only as a last resort. The restraint coordinator discusses alternatives with the resident, family/whānau, GP, and staff. Documentation includes the method approved, when it should be applied, frequency of monitoring and when it should end. It also details the date, time of application and removal, risk/safety checks, food/fluid intake, pressure area care, toileting, and social interaction during the process. However, monitoring when restraints are in use is inconsistent.</p> <p>A restraint register is maintained and reviewed by the restraint coordinator who shares the information with staff at the quality and clinical meetings.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	All restraints are reviewed and evaluated as per Wairarapa Village policy and requirements of the standard. Use of restraints and enablers is evaluated six-monthly or more often according to identified risk. The evaluation includes a review of the process and documentation, including the resident's care plan and risk assessments, future options to eliminate use and the impact and outcomes achieved. Evaluations are discussed at the quality and clinical meetings.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	A review of documentation and interview with the CM demonstrated the monitoring and quality review of the use of restraints. The internal audit schedule was reviewed and included review of restraint minimisation reviews. The content of the internal audits included the effectiveness of restraints, staff compliance, safety, and cultural considerations. Staff monitor restraint related adverse events while restraint is in use. Any changes to policies, guidelines or education are implemented if indicated. Data reviewed, minutes and interviews with

		staff including RNs and health care assistants confirmed that the use of restraint is only used as a last resort.
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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 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	The service had a misunderstanding of the statutory and/or regulatory obligations required regarding notifying relevant authorities in relation to reporting a pressure injury admitted from the DHB and in regard to miss-staging another pressure injury.	The facility has currently two un-stagable pressure injuries which have not been notified as required under section 31 of the Act.	<p>Ensure all statutory and/or regulatory notifications are carried out.</p> <p>90 days</p>
<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,</p>	PA Moderate	<p>i) There is an electronic system used for medication management. However, documentation of allergies and sensitivities on the system is inconsistent, in three out of sixteen medication files reviewed, there was no indication of the resident's allergy/sensitivity status.</p> <p>ii) The RN oversees the use of all PRN medications. However, documentation of</p>	<p>i) Allergies and sensitivities are not consistently documented on the electronic medication system.</p> <p>ii) Effectiveness of PRN medications administered is not consistently documented.</p> <p>iii) The required six-monthly stocktake of medication had</p>	<p>i) Ensure that allergies and sensitivities are documented on the electronic system.</p> <p>ii) Ensure that the documentation of the effectiveness of all PRN medication administered is documented on the electronic medication</p>

protocols, and guidelines.		<p>the effectiveness of the medication given does not always occur. In six out of sixteen files reviewed, effectiveness of medication administered was not recorded on 30 occasions during the previous month.</p> <p>iii) The pharmacy stocktake had not occurred in the past six months. The FM stated that the requirement to complete the stocktake was part of the pharmacy contract, but that the pharmacist had declined to do the stocktake.</p>	not been carried out.	<p>management system.</p> <p>iii) Ensure that the required six-monthly stocktake of medication is completed.</p> <p>30 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>	PA Low	<p>All residents had either an initial care plan or LTCP in place. However, short-term care plans are not developed to guide care for all residents who have an infection. In a sample of four residents who had had an infection, one resident had a short-term care plan in place.</p>	<p>Short-term care plans are not consistently developed to guide the care of residents with an infection.</p>	<p>Ensure that short-term care plans are developed for the care of all residents with infections.</p> <p>180 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>i) There are adequate wound care products available at the facility. However, wound care is not being carried out in accordance with policy. Wound care is not recorded on the electronic system, hard copy is used. In a sample of eight wounds reviewed, seven had no NHI number or correct labelling on the wound care forms. For all eight wounds reviewed no recent measurements of the wounds had been recorded, no photos had been taken. Therefore, comprehensive evaluation of the progress of the wounds was not</p>	<p>i). Wound care is not managed as per Wairarapa Village policy.</p> <p>ii). Routine monitoring of observations and weight is inconsistent.</p> <p>iii) The Wairarapa Village falls policy does not meet best practice recommendations. Neurological observations are not consistently recorded as per existing Wairarapa</p>	<p>i). Ensure that wound care is maintained as per Wairarapa Village wound care policy.</p> <p>ii). Ensure that routine monitoring of observations and weight are carried out consistently.</p> <p>iii). Ensure that the falls management policy aligns with best practice recommendations and that neurological observations</p>

		<p>possible. There were no clear wound treatment plans in place for any of the eight wounds reviewed.</p> <p>ii) There is a system for recording weights and observations monthly. However, this involves the resident being designated 'resident of the day' with a requirement for the RN to ensure that their observation and weight is completed on a designated day and recorded on the electronic system. There is no follow up if this does not occur on the designated day. Review of residents' files demonstrated that the recordings were not done consistently between June and September 2021 in six out of eight files reviewed.</p> <p>iii) All unwitnessed falls have a RN assessment carried out. The Wairarapa Village falls policy stated that neurological observations are to be recorded half hourly for two hours, hourly for four hours and two hourly for 24 hours, then if the residents is considered stable, they can be discontinued. However, observations are not always carried out in line with policy and the policy does not align with best practice recommendations.</p>	Village falls policy	<p>are carried out in accordance with the revised policy.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is</p>	PA Low	The routine maintenance monthly checks ensure that all resident hot water bathroom facilities are within the required temperature range and safe for use by residents. A dining room tap provides boiling water for is freely accessible to	The hospital dining room hot beverage tap is at boiling point and does not have a guard to protect inadvertent scalding.	Ensure that the hot drink water appliance has a guard to prevent injury due to the high water temperature.

appropriate to the needs of the consumer/group.		residents and family/whānau to make a hot drink.		90 days
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Low	The facility has a Fire and Emergency New Zealand (FENZ) fire evacuation plan that was approved in January 2021, however, there have been building alterations since the approval, which include widening of corridors and the movement of fire stop doors and fire cells. A new fire evacuation plan has been submitted to FENZ for approval.	The new fire evacuation plan is yet to be approved by FENZ.	<p>Ensure that approval of the new fire evacuation plan is obtained.</p> <p>90 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a</p>	PA Moderate	Restraint management is documented using the electronic system. However, in four files reviewed of residents' using restraint, monitoring did not occur as required in the Wairarapa Village restraint minimisation policy. The requirement is for two hourly monitoring, however, on several occasions, documentation evidenced that monitoring was occurring twice in an eight-hour period.	Observation and monitoring of residents while restraint is in use is inconsistent and does not comply with policy and best practice.	<p>Ensure that monitoring of restraint use complies with policy and best practice.</p> <p>90 days</p>

result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.				
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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.