Christchurch Methodist Central Mission - WesleyCare

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 Health and Disability Auditing New Zealand 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:	Christchurch Methodist Central Mission
Premises audited:	WesleyCare
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 February 2018 End date: 14 February 2018

Proposed changes to current services (if any): The service is also certified for Hospital – medical level care. This is not documented in the service audited table above.

Total beds occupied across all premises included in the audit on the first day of the audit: 99

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

Wesley Care is governed by the Christchurch Methodist Mission board. A chief executive officer (CEO) is responsible for all aspects of the mission. The residential aged care service provided at Wesley Care is one of four aspects of the boards work. Wesley Care provides care for up to 108 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 99 residents in total.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner.

The facility manager has many years working at Wesley Care in the role of manager. The manager is also supported by a deputy manager (RN), two clinical nurse managers, registered nurses and care staff. Residents and family interviewed were very complimentary of the services and care they receive.

The service is commended for achieving a continued improvement rating around good practice.

This audit identified improvements required timeliness of interRAI assessments and interventions.

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.		All standards applicable to this service fully attained with some standards exceeded.

Wesley Care provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents are encouraged to maintain former links with the community. There are a number of community visitors to the home.

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.

The quality and risk management plan and quality and risk policies describe Wesley Care's quality improvement processes. Policies and procedures are maintained by an aged care consultant who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys. Quality data is discussed at meetings and is documented in minutes. 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. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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 low risk.

The service has implemented interRAI for its assessments and care planning process. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whānau input. Care plans demonstrate service integration. Resident files include notes by the GP and allied health professionals. Medication policies and procedures are in place to guide practice. Education and medication competencies are completed by all staff responsible for administration of medicines. The activities programme is facilitated by diversional therapists. The activities programme provides varied options and activities are enjoyed by the residents. The programme caters for the individual needs and involves community activity. All food is cooked on-site by the in-house chef and cooks. All residents' nutritional needs are identified, highlighted and choices are available and provided, meals are well presented.

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.

Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness which expires 4 April 2018. Rooms are individualised, spacious and uncluttered. Resident rooms are large enough for rest home and hospital level residents. External areas are safe and well maintained. There

are lounges in each area. There are adequate toilets and showers for the client group. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. The facility has overhead panel heating, wall heaters and wall mounted heat pumps which provides air conditioning, so temperature is comfortable and constant.

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.

There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were two residents requiring restraints and three residents using enablers. The service reviews restraint as part of the quality management and staff are trained in restraint minimisation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Responsibility for infection control is the deputy manager. The infection control coordinator has completed on-line training. Staff complete annual training on infection control. There is a suite of infection control policies and guidelines to support

practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility.

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	1	47	0	2	0	0	0
Criteria	1	98	0	2	0	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families in the foyer. A policy relating to the Code is implemented and staff interviewed (one facility manager, one quality manager [deputy manager], four registered nurses [RN], five caregivers, and two activity staff) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service and through the regular in-service programme.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent and advanced directives were recorded as evidenced in the eleven resident files reviewed (three rest home, eight hospital, including one young person with disability). All files were appropriately signed by the resident. Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed.
Standard 1.1.11: Advocacy And	FA	Health and Disability advocacy brochures are included in the information provided to new residents and their family during their entry to the service. Residents and family interviewed were aware of the

Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff receive regular education and training on the role of advocacy services. A health and disability advocate is available to residents/family.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the activity coordinators to ensure that the residents continue to participate in their chosen community group. The service has a van and a car that is used for resident outings and appointments. There are a number of community visitors to the facility including primary school children, guest speakers and entertainers.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice which aligns with Right 10 of the Code. The facility manager leads the investigation of any concerns/complaints in consultation with the deputy manager. Compliments and complaints are discussed at the monthly quality meetings. Complaints forms are visible throughout the facility. There have been two complaints in 2017 including two complaints to the HDC. All complaints have been managed appropriately and the resolution accepted by family members. Residents and families interviewed are aware of the complaints process. A compliments and complaints register is maintained.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The facility manager, RN or deputy manager discuss aspects of the Code with residents and their family on admission. Eleven residents (eight rest home and three hospital) and four family members (one rest home and three hospital) interviewed, reported that the residents' rights were being upheld by the service.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner	FA	Care staff interviewed reported that they knock on bedroom doors prior to entering rooms and this was demonstrated on the day of audit. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit, confirmed that the residents' privacy, culture, values and beliefs is respected. The residents' personal belongings are respected and not for communal use. Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and

that has regard for their dignity, privacy, and independence.		neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care for any residents who identify as Māori. There were no residents who identified as Māori on the day of audit. The service has a long term historical relationship with the iwi Ngai Tahu through Rehua Marae. This year the Christchurch Methodist Mission (CMM) has opened an eight-bedroomed community house for independent Māori elders. The service actively supports Te Reo lessons for staff (including one resident).
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies the residents' personal needs, culture, values and beliefs at the time of admission in consultation with the resident and family. Beliefs and values are incorporated into the residents' care plans. Residents and family interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual cultural and spiritual values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	There is an RN on duty 24 hours a day and an RN available on call for additional support as required. Care staff confirmed on interview they feel supported and their contribution into resident care is valued. Policies and procedures reflect best practice and staff are required to read the new/reviewed policies. Residents and family interviewed reported that they are very satisfied with the services received. There are a range of health professionals involved in the residents' care including the general practitioner, physiotherapist and dietitian. Service improvement has included: The creation of an admission nurse role to ensure the smooth admission of all residents, two relatives are part of the quality team, feedback from these relatives has improved processes around catheter care and instigated the purchase of a fridge in the lounge so

		residents can have easier access to cooled drinks. The service undertakes a two-yearly health and wellbeing survey for staff. As a result of this survey the service has employed a wellbeing staff member. This staff member visits and works to resolve staff issues. A counselling service is also provided. Staff report that this service is valued.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. Residents and family interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry. The facility manager and deputy manager operate an open-door policy. Fourteen incident/accident forms reviewed December 2017 identified family were notified following a resident incident. Family members interviewed confirmed they are notified promptly of any incidents/accidents. Interpreter services are available if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Wesley Care is governed by the Christchurch Methodist Mission board. A chief executive officer (CEO) is responsible for all aspects of the mission. The residential aged care service provided at Wesley Care is one of four aspects of the boards work. The manager of Wesley Care reports to the CEO on a monthly basis. Wesley Care provides care for up to 108 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 99 residents in total – 20 residents at rest home level, and 79 residents at hospital level including three younger persons with disability (YPD) and one palliative. There were no respite residents. The service has been managed by an experienced manager who has been in the role for over 30 years. The manager reports monthly to the board on a variety of management issues. The current strategic plan, and quality and risk management plans have been implemented. The manager (registered nurse) receives support from a deputy manager (registered nurse), two clinical nurse managers, registered nurses and care staff. The manager has completed eight hours of professional development related to managing a rest home and hospital facility.
Standard 1.2.2: Service Management The organisation ensures the day-	FA	In the absence of the manager, the deputy manager is responsible for the running of the facility. There are also two clinical nurse managers who provide assistance and support.

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.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The quality manual and the business, quality, risk and management planning procedure describe the Wesley Care home and hospital's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the quality assurance meeting, and the various facility meetings. Meeting minutes have been maintained. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with registered nurses and healthcare assistants confirmed their involvement in the quality programme. Resident/relative meetings have been held. Data is collected on complaints, accidents, incidents, infection control and restraint use. Annual resident/relative satisfaction surveys are completed annually. Results from the most recent survey (2018) has been collated and an action plan documented, and this is currently being implemented. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. There is a risk management plan is in place. The health and safety coordinator (HCA) interviewed, has level four of the health and safety training. Health and safety is discussed as part of the quality meeting. Staff receive health and safety training during orientation and ongoing. Actual and potential risks are documented on the hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. Falls management strategies include sensor mats, and the development of specific falls management plans to meet the needs of each resident who is at risk of falling.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and	FA	There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident. There is documented timely RN assessment for accident/incidents. Incident/accident data is linked to the organisation's quality and risk management programme and a report presented each month at the quality meeting. Fourteen accident/incident forms were reviewed. Each incident involved a resident clinical assessment and follow-up by a registered nurse. Neurological observations were conducted for

where appropriate their family/whānau of choice in an open manner.		suspected head injuries. The facility manager confirmed their awareness of the responsibility to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies to support recruitment practices. Twelve staff files reviewed (one deputy manager [RN], two clinical nurse managers [both RNs], two RNs, one kitchen manager, one housekeeper and five HCAs) contained all relevant employment documentation. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. Current practising certificates were sighted for the RNs and allied health professionals. The service has an orientation programme in place. Since the previous audit the service reviewed its orientation process and implemented a more robust programme for new staff. Healthcare assistants interviewed believed new staff were adequately orientated to the service on employment. There is an annual training and education programme and healthcare assistants are supported to complete careerforce papers. Attendance at training has been identified as low by the service and management have implemented a corrective action around managing this. Clinical staff complete competencies relevant to their role, including medication competencies, manual handling and wound care. Fifteen of eighteen RNs have completed interRAI training. Some of our RNs and ENs are currently completing Palliative Care modules at the moment. RNs are supported to complete external courses.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Residents, relatives and staff interviewed stated there were sufficient numbers of staff on duty to safely deliver residents cares. The facility manager and deputy manager are full-time Monday to Friday and provide on-call. The service employs an admission RN whose role is to ensure the smooth admission of residents, undertake the first interRAI, the admission assessment and care plan and liaise with referrers and the GP. All wings apart from purple (rest home only) are hospital wings. The service has up to ten dual-service beds in any of the wings. The upstairs is led by an RN clinical nurse manager. It has two units of up to 25 residents each, (blue and red wings) each staffed separately. Each unit has the following staffing each: AM; one RN, and six HCAs (four long shifts and two short)

		PM; one RN and four HCAs (three long and one short shift) Night; one RN and three HCAs. The downstairs is led by an RN clinical nurse manager. It has three units (green, purple and orange) each staffed separately. Each unit has the following staffing each: Green (up to 23 hospital level) this wing has additional staffing due to two bariatric residents. AM; one RN and six HCAs (four long and two short shifts) PM; one RN and four HCAs (three long and one short shift) Purple (up to 16 rest home level) AM; one enrolled nurse Monday to Friday and three HCAs (two long and one short shift) PM; two HCAs (one long and one short shift) Orange. (Up to 19 residents), this wing also includes the studio rooms AM; one RN and four HCAs (two long and two short shifts) PM one RN and three HCAs (two long and one short shift) The night cover for all of the downstairs is; one RN and three HCAs. There is the flexibility on the roster to increase hours to meet resident acuity.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are stored securely. Residents' files demonstrate service integration. Entries are legible, dated, timed and identifiable, including designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has	FA	Wesley Rest Home and Hospital has documented interRAI assessment processes and residents' needs are assessed on entry. The service has a comprehensive admission policy. Residents and/or relatives are provided with information in relation to the service. Information gathered at admission is retained in the residents' records. The residents and family members interviewed stated they were well informed upon admission.

been identified.		
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a transfer plan policy. A record is kept, and a copy is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are comprehensive medication policies in place. The service has an electronic medication system in place. All medication administering follows safe medication guidelines as set down in the policies. Medication fridge temperatures are monitored weekly. Medication reconciliation is completed on admission and the policy includes guidelines on checking medications on arrival. All staff administering medications have completed an annual medication competency. Staff were observed safely administrating medications. At the time of audit there were residents' who were self-administering medications, and all had competencies completed and reviewed by the GP three monthly. Twenty-two medication charts were reviewed. All meet legislative guidelines and administration charts are documented accurately.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Wesley Rest Home and Hospital has two large well-equipped kitchens. The menus are designed by the chef and moderated by a dietitian. There is a summer and winter four-week rotational menu. All meals are prepared in the two main kitchens and served from the kitchen directly to the residents' in the main dining room, and the 'café' dining rooms. Diets are modified as required. The chef confirmed that there are alternatives available. Any changes to nutritional requirements are communicated to the cook by the registered nurse. Additional snacks are available when the kitchen is closed. Kitchen fridge, freezer and food temperatures are monitored and documented.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their	FA	There are records kept, of reasons for any declined entry; due to there being no beds available or else the unavailability of required level of care. On interview management were able to discuss the process of declined entry and support and alternatives for those declined.

family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Wesley Rest Home and Hospital have adopted the interRAI assessment tool as evidenced in resident files sampled. These were not always reviewed at least six monthly and have been used to assess level of risk and required support (link to 1.3.3.3). All eleven resident files reviewed included an individual assessment that included identifying diversional, motivational and recreational requirements.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Care plans demonstrate service integration and demonstrate input from allied health professionals. Short-term and long-term care plans reviewed were completed by registered nurses. Care plans reviewed provide evidence of individual support, however do not document nursing interventions for unintentional weight loss or managing challenging behaviours. Short-term care plans were in use for changes in health status however, not all documented nursing interventions. Resident files reviewed identified that family were involved.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Eleven resident files were reviewed, three from rest home, eight from hospital including one young person who required palliative care. All residents interviewed stated their needs were being appropriately met. Dressing supplies are available, and a treatment room was stocked for use. Continence products are available and were identified for daytime and night use, plus any other management. Procedures for wound assessments, evaluation and nursing interventions were in place as evidenced in the wound management folder. There were short-term care plans in place for acute resident problems. There is a suite of monitoring charts available including weight and vital signs, behaviour monitoring, restraint monitoring, pain, and blood glucose monitoring. Palliative care specialist nurse service has been accessed for palliative care residents.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There are two diversional therapists, and one activity coordinator that provide an activities programme over five days each week with separate programmes in the hospital and rest home and some combined activities. The programme is planned monthly and residents receive a personal copy of planned monthly activities. A diversional therapy plan was developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities. The service has a van and a car that is used for resident outings and appointments. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities.

		Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The evaluation and care plan review policy require that long-term care plans are reviewed six monthly, or as residents' condition changes. The care plan evaluations reviewed described progress against set goals and needs identified in the care plan (link 1.3.3.3). Short-term care plans were utilised when required. Any changes to the long-term care plan were dated and signed by the registered nurse. Progress notes were comprehensive, and evidence follow-up by RN when resident condition changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussions with the clinical managers and registered nurses identified that the service has access to specialist nursing services such as continence nurses, palliative care services and wound specialist nurses.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Product use charts are available, and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been completed.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Wesley Rest Home and Hospital provides a clean and safe environment, which is well maintained and appropriate for its purpose. Reactive and preventative maintenance occurs. The building holds a current warrant of fitness that expires 4 April 2018. Electrical equipment is checked annually next due on 3 July 2018. The external areas are well maintained, and gardens are attractive. There is wheelchair access to all areas. The service has a van and a car used for transporting residents, both with current warrant of fitness and registration.

		The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are smaller, quieter lounges for residents and visitors. All required equipment is available. The outside area for residents is well designed and appropriate for residents who like to go outside, seating and tables are provided, shade is provided by umbrellas and the design of the building provides sunny areas and shaded areas.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	The hospital and rest home include sufficient toilets and showers for the residents, and all resident rooms are ensuite. There are also adequate toilet facilities for use by staff and visitors. Communal toilets and bathrooms have appropriate signage and shower curtains installed.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The rooms are spacious, and wheelchairs, hoists and the like, can be manoeuvred around the bed and personal space, for those indicated. Caregivers interviewed report that rooms have sufficient space to allow care to take place. Residents interviewed voiced their satisfaction with the size of their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a lounge and separate dining rooms in the hospital building, and the rest home/hospital apartments. All lounge/dining rooms are also accessible and accommodate the equipment required for the residents. Residents are able to move freely, and furniture is well arranged to facilitate this.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe	FA	All laundry is done on-site and there are dedicated laundry and cleaning staff. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer's labels. There are sluice rooms for the disposal of soiled

and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		water or waste. These are locked when unattended. Residents interviewed confirmed that the facility was kept clean.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 5 December 2017. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. There is a qualified first-aider each shift. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, and gas cooking. Short-term backup power for emergency lighting is in place. All areas including resident rooms, toilets and communal areas have call bells. Residents were observed to have their call bells in close proximity.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The facility has a mix of overhead panel heating, heat pumps and wall mounted heaters which can be controlled in each area/room; rooms are well ventilated and light. Facility temperatures are monitored monthly. There is plenty of natural light in resident's rooms.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The deputy manager (RN) has overall responsibility for infection control across the facility. There is also a designated infection control coordinator (RN). Responsibility for infection control is described in the job description. The infection control coordinator oversees infection control for the service and responsible for the collation of infection events. The infection control programme is reviewed annually by the infection control team as part of the quality meetings. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.
Standard 3.2: Implementing the	FA	The infection control committee are representative from each service area as part of the quality meetings. The infection control coordinator regularly attends the DHB infection control meetings and

infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		is part of the DHB IC committee. There is access to infection control expertise within the DHB, aged care consultant, external infection control specialist, wound nurse specialist, public health, laboratory and microbiologist. The GP monitors the use of antibiotics.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping, incorporate the principles of infection control. The policies have been developed by Bug Control.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation. Hand hygiene competencies are completed during orientation and annually. Resident education occurs as part of providing daily care.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. A registered nurse is the designated infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly facility infection summary and staff were informed. The data has been monitored and evaluated monthly.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service is committed to restraint minimisation, and safe practice was evidenced in the restraint policy and by interviews with clinical staff. Restraint minimisation is overseen by restraint coordinators who are the clinical managers. There were two residents requiring restraint. Restraints used were three-point harness. There is evidence in the progress notes of alternatives considered, and relative's involvement prior to restraint. Three residents were using a bedrail as enablers. The use of enablers is voluntary, and requested by the resident. A full restraint assessment is completed prior to implementing the enablers. There is evidence of the residents consenting to the enabler.
Standard 2.2.1: Restraint approval and processes 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.	FA	The restraint coordinators are the two clinical managers (registered nurses) and a registered nurse. Assessment and approval process for a restraint intervention included the restraint coordinator, registered nurse, resident/or representative and medical practitioner.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinators, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the two files reviewed assessments and consents were fully completed. Consent for the use of restraint was completed with family/whānau involvement and a specific consent for enabler/restraint form was used to document approval.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identified that restraint is only put in place where it was clinically indicated and justified and approval processes. There is an assessment form/process that was completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan intervention. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. The two files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. The service has a restraint and enablers register which is updated each month.

Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the restraint coordinators at the quality meeting and at the three-monthly restraint meeting. Evaluation timeframes are determined by risk levels but at least every three months. The evaluations have been completed with the resident, family/whānau, restraint coordinator and medical practitioner.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified by the restraint coordinators. Any adverse outcomes are included in the restraint coordinators monthly reports and are reported at the monthly meetings. There are three monthly restraint meetings held.

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)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Initial care assessments and care plans were completed, though not all within the three-week timeline. Long-term care plans were on the interRAI assessment system so triggered only needs to be met. InterRAI assessments were not always reviewed within six months.	(i) One rest home level and three hospital level files reviewed had overdue initial interRAI assessments. (ii) Two rest home and three hospital files reviewed showed an interRAI assessment had not been reviewed within six months.	(i)- (ii) Provide evidence that interRAI assessments are consistently completed within timeframes. 60 days
Criterion 1.3.5.2 Service delivery plans describe the	PA Low	Of the 11 resident files reviewed, the long and short-term care plans reviewed did not always document comprehensive nursing interventions for managing change in status, such as	Three rest home and three hospital files reviewed did not have comprehensive nursing interventions, for example, unintentional weight loss and management of challenging	Ensure that care plans document comprehensive

required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.		challenging behaviours or weight loss. Individual de-escalation and diversion techniques were evidenced in behaviour monitoring charts. Some nursing interventions for weight loss were documented in the progress notes.	behaviours. One resident with recurrent urinary infections did not have a short-term care plan in place and no nursing interventions were documented in the long-term care plan. This was updated during the audit.	nursing interventions. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The service is a stand-alone not-for-profit organisation. Their model of care is ‘resident centred care and they focus on maintaining an excellent reputation in the community for both end-of-life care and aged residential care. The service does not charge for any extras and they employ a resident advocate to support residents. Advised there is a strong relationship with the CDHB Needs Assessor Teams and the Nurse Maude Palliative team. Registered nurses and clinical managers are supported to complete post-grad papers in gerontology. There are two consumer representatives on their Quality Health and Safety committee which allows transparency and ensuring the	The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Example: There are two consumer representatives on their Quality Health and Safety committee which allows transparency and ensuring the resident’s voice is heard. Issues that are important to the residents are advocated for by the representatives. Topics initiated by the representatives are included in the meeting. The agenda and minutes are available to the representatives before and following meetings. An evaluation has been completed annually as to how valuable the management and advocates find the advocates input into the meeting. This has received positive feedback

		resident’s voice is heard.	including feedback on transparency, and being resident-focus.

End of the report.