

M & K Atkins Limited - The Waratah Retirement Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	M & K Atkins Limited
Premises audited:	The Waratah Retirement Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 May 2018 End date: 9 May 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	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.

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

Key to the indicators

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

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

General overview of the audit

The Waratah Retirement Home provides rest home and hospital level care for up to 58 residents. The service is operated by M & K Atkins Limited and managed by the owner/manager. The owner manager is supported by a clinical team leader. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family, management, staff and a general practitioner.

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

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.	Green	Standards applicable to this service fully attained.
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The residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Rights (the Code) and these are respected. Services and care provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. From observation and staff interviews there was no evidence of abuse, neglect or discrimination.


Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with information they need to make informed choices and give consent and act on any advance directives.

Residents who identify as Maori have their needs met in a manner that respects their individual cultural values and beliefs.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business, quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the owner/manager is regular and effective.

The quality and risk management system includes collection and analysis of quality improvement data, identifies any trends and leads to improvements. Staff are involved in the internal monitoring of service delivery and feedback is sought from residents and families. Adverse events are electronically maintained and recorded with corrective actions implemented. Actual and potential risks, including health and safety risk are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation/induction and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular performance reviews. Staffing levels and skill mix meet the changing needs of the residents.

Resident information is accurately recorded and is securely stored and not accessible to unauthorised people. Up to date, legible and relevant records are maintained using integrated records. Archived records are stored appropriately and can be retrieved if and when necessary.

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.
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The admission process into the facility is managed by the owner / manager and the clinical team leader. The general practitioner is involved in the admission process. Residents' medical admissions are completed in a timely manner. Nursing assessments are completed on admission and the assessment outcomes are used to complete care plans. The registered nurses are responsible for developing the care plans. Care plans and interRAI assessments are completed in a timely manner.

The service uses pre-packed medication system and are in the process of changing over to electronic medication management system. There are policies and procedures that clearly document the service provider's responsibilities in relation to each stage of medicine management. Competent staff administer medications. All medication administration competencies are current.

Activities provided are meaningful to the residents and reflect ordinary patterns of life. The activities coordinator plans the activities in consultation with residents and family/whanau where appropriate.

Food, fluid and nutritional needs of residents are provided in line with the recognised nutritional guidelines appropriate to the residents' needs. The food services are provided at the facility.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested annually. Communal spaces are maintained at a comfortable temperature. External areas are accessible and safe. Waste management and hazardous substances are effectively managed. Staff use protective equipment and clothing. Chemicals and equipment are safely stored. Laundry and cleaning services are managed on-site and products used are evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported timely response to call bells. Security is maintained by staff.

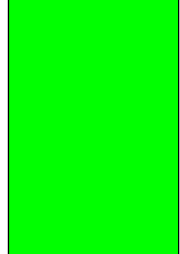
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The use of restraint is actively minimised by ensuring ongoing staff education on challenging behaviour management, alternative interventions to restraint and de-escalation techniques. There is restraint minimisation policy and procedures that clearly outline the

process of restraint approval, monitoring requirements and safe use guidelines. On the days of the audit, there was one residents using bedrails as restraint and no enablers in use.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme is developed in consultation with the relevant key stakeholders. The environment is managed in a way that minimises the risk of infection to residents, staff and visitors. The risk assessment process, monitoring and surveillance data, trends and relevant strategies are carried out in accordance with objectives and methods specified in the infection control programme. The registered nurse is the infection control coordinator. There was no infection outbreak reported since the last 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	49	0	1	0	0	0
Criteria	0	100	0	1	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the staff training and online education programmes. Residents' rights are upheld by staff. Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents reported that they understand their rights. The family/whānau reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided to those family members/representatives with enduring power of attorney (EPOA) and ensuring where applicable this is activated.</p> <p>There is a policy on advance directives and advanced care planning which meet legislative requirements. An advance directive and advance care plan are used to enable residents to choose and make decisions related to end of life care. The records reviewed had signed advance directives which were reviewed six monthly along with the care plan reviews.</p>

		Residents and family/whanau (where appropriate) are included in care decisions.
<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>Advocacy information is available in brochure format at the entrance to the facility. Residents and family/whanau are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the staff training schedule 2018 reviewed. The staff interviewed reported knowledge of residents' rights and advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents reported they are supported to maximise their potential and to maintain links with their family and the community through shopping trips, activities, outings and walks. Policy includes procedures to be undertaken to assist residents to access community services and a mobility van is available with a designated driver who plans all outings with the activities coordinator. The facility has unrestricted visiting hours and encourages visits from resident's family and friends. Family interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The compliment/complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents/family/representative on admission and there is complaints information and forms available in a number of areas in the facility.</p> <p>The complaints register reviewed and showed one complaint has been received since the previous audit. This complaint was followed through and all steps for resolution are documented accurately, time frames are appropriate and all records are maintained dated and signed off as specified in the Code. A corrective action plan for quality improvement has been developed and implemented. The complaint remains open as not closed out as yet by the DHB. There have been no other complaints received from external sources since the previous audit.</p> <p>The owner/manager and the quality systems/auditing manager manage complaints and these are discussed at the clinical governance meeting. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	FA	<p>A copy of the Code and other information related to rights are in the residents' rooms and displayed throughout the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families as confirmed by interviews with clinical staff. Discussions related to</p>

rights.		<p>residents' rights and responsibilities take place formally in staff meetings and training forums and informally (e.g., with the resident in their room). A copy of the Code is available in sign language. Residents and family/whanau report that the residents are addressed in a respectful manner that upholds their rights.</p> <p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service as part of the admission information provided and discussion with staff.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit. Privacy is considered when attending to personal cares. The staff ensured resident information is held securely and privately and that privacy is observed when having conversations with residents and family. All residents' have their own room and this also ensures privacy is maintained.</p> <p>Residents are encouraged to maintain independence by attending activities in the community or by attending groups, clubs and organisations that they were attending prior to admission. Each plan included documentation related to the individual resident's abilities and strategies to maximise independence.</p> <p>Records confirmed that each resident's individual cultural, social and religious needs, values and beliefs had been identified and documented in their care plan.</p> <p>Staff understood the service's policy on abuse and neglect including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff and is then provided on an annual basis as confirmed in the staff and training records reviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Te Tiriti O Waitangi policy (Treaty of Waitangi) is available to guide staff. A family/whanau approach to service delivery is encouraged. Whanau input and involvement is sought as required for all cares and decision making. The staff training schedule sighted includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whanau. The staff and whanau interviewed reported that there are no known barriers to Maori accessing the services.</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>The cultural and spiritual needs of the residents are provided in consultation with the resident and the family/whanau as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Residents verified that they were consulted on their individual ethnicity, culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</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>Residents and family/whanau reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation/induction process for staff includes education related to professional boundaries, expected behaviours and code of conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies and input from external specialist services and allied health professionals. The service has access and support from specialist gerontology nurse specialists, wound care nurses and geriatricians as needed. The general practitioner (GP) visits the service at least weekly. Resident and family satisfaction surveys evidenced overall satisfaction with the quality of care and services provided.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included the content covered in the staff training as per the staff records and the training records reviewed. Quality projects are underway for incidents/accident management and other quality and care initiatives.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Residents and family members stated they were kept informed about any changes to their/their relative's health status and were advised in a timely manner about any incidents or accidents and</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>outcomes of regular and any urgent medical reviews. This was supported in the residents' records reviewed. Staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services through the DHB though reported this was rarely required due to most residents being able to communicate effectively in English and/or staff were able to translate as needed. There is an interpreter service available for any deaf residents to access if needed. There are communication strategies in place for residents with any cognitive impairment or those who have non-verbal means of communication.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plan is reviewed in January of each year. The mission statement, values and quality objectives are documented. The documents reviewed outlined and described longer term objectives and the objectives for 2018. A sample of reports to management showed information required was reported as requested by the owner/director.</p> <p>The service is managed by the owner/manager who has management experience and has been in the role for 25 years. Responsibilities and accountabilities of the owner/manager position are defined in a job description and individual employment agreement. The owner/manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains ongoing education by attending related business courses and forums and has membership in sector aged care related associations.</p> <p>The service holds aged residential care contracts with the DHB for up to 58 residents. There were 57 residents receiving services on the day of this certification audit. Rest home level care (41) and (16) hospital geriatric and medical level care residents and respite care (Nil).</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the owner/manager is absent the clinical team leader carries out all the required duties under the delegated authority with support from the quality systems/auditing manager. During absences of key clinical staff the clinical management is overseen by one of the senior registered nurses who are experienced in the sector and are able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk</p>	<p>FA</p>	<p>The Waratah retirement home has a robust system for reviewing any new/draft and/or existing policies.</p>

<p>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>All legislative requirements are documented. Any obsolete documents are able to be stored in a locked room. All electronic records are stored on a back-up system. An archive system is utilised and records can be retrieved as needed.</p> <p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement and is understood by staff. This includes the management of incidents and complaints, audit activities, a regular resident/family satisfaction survey, monitoring outcomes, clinical incidents, infection prevention and control, restraint minimisation and safe practice.</p> <p>Terms of reference and meeting minutes reviewed confirmed more than adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of key quality indicators occurs and related information is reported and discussed at the quality/staff meetings. Minutes of meetings reviewed evidence discussion on all quality indicators. Staff reported their involvement in quality and risk management activities through the internal audit activities that they are involved in where possible. The clinical team leader collates all data and this is reported to the quality systems/auditing manager who analyses the information. Graphs and summaries are developed and discussed at the quality meetings. Relevant corrective actions are developed and implemented to address any shortfalls and demonstrated a continuous process of quality improvement is occurring. Any risks identified are rated and monitored. Resident and family surveys are completed annually. The outcome of the November 2017 survey provided positive comments for all staff and management.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. The registered nurse enters the incident/event onto the electronic incident system and this is checked every morning by the quality systems/auditing manager. Once entered the hard copy form is placed in the individual resident's record. Incident reports are generated monthly. The clinical team leader analyses and summarises all incidents. Incidents are discussed at the monthly quality meeting and quality improvements are completed if and when needed.</p> <p>The owner/manager and the quality systems/auditing manager described essential reporting requirements, including reporting on pressure injuries. They advised there have been no notifications made since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>Human resource management policies and procedures are based on good employment practice and relevant legislation. The recruitment process includes reference checks, police vetting and validation of qualification and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Induction booklets were sighted. Staff records reviewed showed documentation of completed orientation and a performance/appraisal review after a three month period and annually.</p> <p>Continuing education/training is planned on an annual basis and includes all mandatory training requirements. Care staff have either completed or commenced a New Zealand qualification authority programme to meet the requirements for the provider's agreement with the DHB. The qualify systems/auditing manager and the clinical team leader facilitate the education/training programme. A training schedule for 2018 was available. A record is maintained of all staff who have completed first aid training and renewal dates. One staff member has completed advanced first aid. There are sufficient numbers of trained and competent registered nurses (three trained and one in training) who are maintaining their annual competency requirements to undertake interRAI assessments.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy details staffing levels and skill mix requirement and this aligns with the requirements of the provider's contract with the DHB.</p> <p>The current roster was reviewed and demonstrated that there was a clinical team leader on Monday to Friday plus on-call. The senior registered nurses cover seven days a week 24 hours a day. The owner/manager works Monday to Friday and is on call for non-clinical calls 24/7. There are adequate numbers of caregivers on all shifts to cover this facility. There are two activities co-ordinators who cover the week Monday to Friday. A designated van driver takes the residents on outings in the community during the week days. The designated driver is also the maintenance person for this facility. An administration manager is available Monday to Friday and is on call as required.</p> <p>The kitchen staff consist of a head cook who works Monday to Friday and a weekend cook. Kitchen assistants are available. Tea cooks cover the evenings. Housekeeping is managed by the head housekeeper and the service is covered Monday to Sunday for all areas of the facility.</p> <p>All caregivers interviewed report that there is adequate staff available and that they are able to get through their work. The registered nurses confirmed that the clinical team leader or the owner/manager are available out of hours if required.</p> <p>Residents and family members interviewed confirmed staffing meets their needs.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was completed in the residents' records sampled for review. Clinical notes were current and integrated with general practitioner and allied health service provider records. This includes interRAI assessments information entered into the</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>electronic database. Recent records sampled were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable. Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' admission process into the service is managed by the owner /manager, the clinical team leader and the registered nurses (RNs). The facility brochure is clearly documented and access processes and entry criteria are communicated to the consumers, their family/whanau where appropriate, local communities and referral agencies. Pre- admission forms are completed and information pamphlets and the facility brochure are provided at pre-entry stage. Family is involved in the admission process by completing the admission form that provides contact information and in formulating the residents' care plans.</p> <p>Risk management forms are completed on admission by the RNs. Documentation was sighted in the sampled files.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a process in place to identify and minimise risks associated with residents' transition, discharge, exit or transfer managed by the owner/ manager and the clinical team leader. Discharge or transfer documentation is completed. Yellow envelopes and DHB transfer forms are completed for all transfers to the DHB. Follow up is completed by the clinical team leader to ensure safety of the resident. Documentation was sighted in sampled files. Family/whanau and resident representatives of choice are involved in the transfer process.</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 Low	<p>There are policies and procedures in place that clearly document the service provider's responsibilities in each stage of medicine management. All staff responsible for medication administration are competent with current medication administration competency. Medication administration competencies are conducted by suitably qualified personnel. Medication management training records were sighted. The service is in the process of changing over medication management system to the electronic system.</p> <p>There is a policy for medication self-administration that guides staff in the process for safe self-administration. There are residents who are self-administering medicines and are assessed as competent by the GP in consultation with the RNs and the clinical team leader. Their medication is stored safely in the locked medication trollies and medication cupboards in the nurses station. The</p>

		<p>medication is given to them at regular medication rounds by the nurse or caregiver administering medication and they take the medication with oversight. Administration records are maintained. Assessment forms were sighted in sampled files. Completed informed consent forms were sighted in sampled files. Three monthly medication self-administration competency is completed by the GP in consultation with the RNs and clinical team leader.</p> <p>Three monthly medication reviews are completed by the GP. Allergies or sensitivities are documented on the prescription charts and residents' photos are used as part of resident identification method.</p> <p>The RN was observed administering medication and safe practice that comply with legislation and guidelines were demonstrated.</p> <p>There are controlled drugs on site and weekly and six-monthly stock takes were completed. Medication is safely stored in locked cupboards. There is emergency stock of antibiotics on site and their use is monitored regularly. There was no expired medication on site.</p> <p>An improvement is required in evaluation of PRN medication and review of short course medication.</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>Food services are provided at the facility. There are five cooks who are all trained in food safety and handling. Food handling training certificates were sighted. There is a food procurement process in place that is managed by the head cook and the owner/manager. A diet profile is completed on admission and whenever there are changes to dietary requirements of a resident and a copy is given to the kitchen. Food preferences, allergies, likes and dislikes are documented on the diet profile. Special and modified diets are provided when required.</p> <p>The kitchen was observed to be clean on the days of the audit. The fridges and freezers were clean and well packed. Fridge, freezer and food temperature monitoring records were sighted. Interviewed staff demonstrated awareness of infection control measures when handling food. Kitchen staff were observed to be wearing appropriate protective equipment and adopting appropriate food safety procedures that comply with current legislation and guidelines.</p> <p>Interviewed residents reported satisfaction with the food services. Alternative food is offered and residents are given a choice per rising need. Meals are served at times that reflect community norms. Assistance is offered to the residents when required.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the</p>	<p>FA</p>	<p>A process is in place for managing immediate risk to the consumer and/or their family/whanau when entry to service is declined and a record is kept. When entry to services has been declined, the consumer and where appropriate their family/whanau are advised of the reason for the decline and are</p>

service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		given options or alternative services.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Internal risk assessment tools are used to assess the residents' needs, support requirements and preferences on admission. InterRAI assessments are completed in a timely manner. The assessed needs, outcomes and goals identified through the assessment process are documented to serve as a basis for service delivery. Assessments are conducted in a safe and appropriate setting as confirmed by the interviewed GP. Assessment outcomes are communicated to the residents and/or their family/whanau and referrers and relevant service providers. Documented communication in progress notes was sighted in sampled files.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Residents' long-term care plans and short-term care plans are individualised, accurate and up to date. Residents, their family/whanau and equivalent key workers are involved in the care planning process. The care plans describe the required support to achieve the desired outcomes identified by the ongoing assessment process. Service integration was sighted in the sampled residents' files.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents receive adequate and appropriate services to meet their assessed needs and desired outcomes. Interventions are appropriate to meet the residents' assessed needs and desired outcomes. Interventions are updated when required and interRAI triggered outcomes are addressed. Specialist advice is sought from other service providers and specialist services when required. Referral documents to other services and organisations involved in residents' support were sighted in the sampled files. Interviewed families and residents reported that they were satisfied with the services provided. Interviewed staff reported that there are adequate resources to meet safe resident care. Adequate resources were sighted onsite and appropriate to the size of the facility.
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	FA	Activities are planned by the activities coordinator in consultation with the owner/manager. There are weekly activities plans posted on the activities boards that are accessible to residents. The activities provided take into consideration, residents' interests and ability. Residents and their family where appropriate are consulted in the activities assessment and planning process. There is a wide range of activities offered including: housie; quiz; music sessions; walking groups; gardening and church services. There is community involvement with external entertainers invited, animal therapy and visits

the service.		<p>from preschools. There is a coach outing from Monday to Friday. Activities participation is completed daily, documentation sighted. Evaluation of the activities plans are completed six monthly by the activities coordinator and countersigned by the RN.</p> <p>Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans and short-term care plans are evaluated in a comprehensive and timely manner. The evaluations are resident focused and indicate the degree of achievement of the desired outcome. Where the desired outcome is not achieved, interventions are changed or altered. When acute conditions are resolved, short term care plans are signed off or closed.</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>Residents are referred to other health and disability service providers when required. Referral documents were sighted in the sampled files. The owner/ manager, RNs, clinical team leader and the GP are involved in the referral process in consultation with the residents and/or their family where appropriate. Informed consent, general consent forms and referral documentation sighted in sampled residents' files. Residents and/or their family are advised of their choice to access other health and disability services where indicated.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage any chemicals and cleaning products and they also provided relevant education/training for staff. Material data sheets and product information was available where chemicals were stored and utilised. Staff interviewed knew what to do should any chemical spill/event occur. A spill kit was available and accessible if needed.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>A current building warrant of fitness (BWOFF) dated expiry 16 June 2018 was sighted. This information was framed and displayed at the entrance to the facility. Management were aware fully aware that this</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>was soon to expire and processes were in place for a new BWOFF to be issued.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the maintenance person and observation of the environment. There is a maintenance plan for preventative and reactive maintenance. Efforts are made to ensure the environment is hazard free and that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Residents/family interviewed confirmed they know the processes they should follow if any repairs or maintenance is required. Hot water temperature is monitored and recorded on a monthly basis and any variances are actioned immediately. They commented that any requests are appropriately actioned and that they are pleased with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All individual resident's rooms have ensuite bathrooms. Each ensuite has a basin and vanity cupboard, walk in shower and toilet. Appropriately secured and approved hand rails are provided in each bathroom sighted. Other equipment/accessories are available to promote resident' independence. There are separate toilets allocated for staff and visitor use. Signage is available.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms are personalised with furnishings, photographs, paintings and other personal effects displayed to promote a homely atmosphere. There is adequate room to store mobility aids, wheelchairs and hoists. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. There are two large and two smaller lounges. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy if required. Furniture is comfortable and appropriate to the setting and meets the residents' needs.</p>

<p>safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Personal laundry only is undertaken onsite in a designated laundry. Housekeeping staff interviewed demonstrated a sound knowledge of the laundry processes, dirty clean flow and handling of soiled linen. Personal protective equipment was readily available. The laundry has a sluice facility and washing machines and driers are commercial standard which are checked regularly and maintained by a contracted service provider and overseen by maintenance personal. All material data sheets and product information is accessible in the laundry. Residents/families interviewed reported the laundry is managed effectively and personal clothing is returned in a timely manner by the housekeepers and care staff.</p> <p>There are designated housekeepers who have had appropriate training for both the laundry and cleaning. Chemicals are stored in a lockable cupboard and were in appropriately labelled containers. The housekeeper's trolley was stored safely in a locked room when not in use.</p> <p>Both cleaning and laundry processes are monitored through the organisation's internal audit programme on a regular basis.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The facility is closely linked with the district health board (DHB) emergency plan and Auckland DHB emergency operations centre. The current fire evacuation plan was approved by the New Zealand Fire Service 25 May 2015. A trial evacuation drill took place last on the 4 April 2018. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency including food, water, blankets, mobile phones, torches, batteries and a gas barbeque are available. Other resources are available and are regularly checked with the checklist developed and implemented. Emergency lighting is tested regularly.</p> <p>A nurse call system is available for residents to use if requiring assistance. Call bell audits are completed and residents and families interviewed reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and rechecked on rounds by the care staff when checking on the residents.</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>	FA	<p>All residents' rooms and communal areas are heated and ventilated properly. All rooms have natural light and opening external windows. There are electric heaters in all service areas and in each individual resident's room. Guards are provided around the heaters in the small lounges to promote safety. One small lounge is glassed in as a sunroom and is enjoyed by the residents. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facility is maintained at a comfortable temperature.</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>	FA	<p>There is an infection control programme which minimises risk of infection to residents, staff and visitors. The infection control programme is reviewed annually, documentation was sighted. It is appropriate to the size and nature of the service. The infection control policies and procedures clearly define the responsibility of infection control and there are clear lines of accountability for infection control matters in the organisation leading to the senior management.</p> <p>There are infection control posters and disinfection agents at the front entrance to increase awareness to residents, staff and visitors on prevention and minimising spread of infections. Staff, residents and visitors who are infectious or exposed to infection are prevented from exposing others while infectious.</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 is adequate human, physical and information resources to implement the infection control programme that meets the needs of the organisation. The infection control coordinator is the RN and has access to expert advice from the local DHB and the GP to achieve the requirements of this Standard. Interviewed staff reported that they have adequate infection control resources to observe appropriate infection control measures.</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</p>	FA	<p>There are written policies and procedures for prevention and control of infection which comply with relevant legislation and current accepted good practice. The policies and procedures are practical, safe and appropriate for the type of service provided. The infection control policy and procedures folders are accessible to all staff. The infection control job description is in place.</p>

and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>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>Relevant education on infection control is provided to all staff at orientation and annually by the infection control coordinator. Infection control training records were sighted. The infection control coordinator is newly appointed, one month in the position and is booked for external infection control training. Infection control was part of the infection control coordinator's induction programme. They are currently working under the guidance and help of the clinical team leader. When interviewed, the infection control coordinator and caregivers demonstrated knowledge on the infection control procedures that comply with current legislative requirements. Residents' education is provided in a manner that meets the residents' communication method or style. Documentation sighted in the short-term care plans for acute infections.</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>The infection control programme states what type of infection surveillance is required and the frequency with which it is undertaken. The infection control statistics are collected monthly. An infection control analysis summary is completed every month and discussed in the clinical meeting monthly. Recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated and reported in a timely manner. Interventions to address the identified issues are discussed in the clinical meeting and at handover times per rising need. An infection report is completed and infections are signed off when resolved. Antibiotic usage is monitored through infection report. Infection register was sighted. Hand washing audits are completed twice per year. An infection control annual report was completed. There were no infection outbreaks reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Waratah retirement home has restraint minimisation policies and procedures that clearly document the risk assessment process and communicate its commitment to restraint minimisation. The definition of restraint and enabler are clearly stated in the organisation's restraint policy. There was one resident using bedrails as restraint and no resident using an enabler. The organisation's policy states that approved methods of restraint and enablers are bedrails, lap belts and harness. Interviewed staff demonstrated knowledge on the difference between an enabler and a restraint. The service advocates for the least restrictive method of restraint to be used. Information about enablers is included in the facility brochure.</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>	FA	<p>The clinical team leader is the restraint coordinator and is involved in the restraint use approval and assessment process in conjunction with the GP, family and resident where appropriate. The restraint coordinator's job description was sighted and it clearly outlines the lines of accountability for restraint use. The responsibility for restraint process and approval is clearly defined in the restraint policy and procedures. The restraint in use is reviewed regularly. Interviewed staff demonstrated knowledge on the restraint approval process and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>There is rigorous assessment of residents in relation to restraint use. The restraint assessment process includes risks associated with restraint use, maintaining culturally safe practice, desired outcome and underlying causes for the current behaviour. The resident's family/whanau was informed of the need for restraint use. The restraint assessment, authorisation and evaluation forms were sighted in the sampled file. Alternative methods were implemented before restraint use authorisation. Informed consent for restraint use was sighted. The restraint policies and procedures identify how often the assessment for restraint use occurs. Restraint use was documented in the resident's care plan with adequate information for the safe management of the resident when using restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The frequency of monitoring of the resident during restraint is determined by the risks associated. The resident was monitored half hourly. Restraint monitoring and observation records were sighted. The restraint use documentation was detailed and included the indication for use, interventions, de-escalation techniques that were attempted prior to restraint use, duration, expected outcome.</p> <p>A current restraint register with adequate information to provide auditable records is in place.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service ensures that restraint evaluation is conducted in collaboration with the resident and their family/whanau. The observations and monitoring are adequate to maintain the safety of the resident. The interval between evaluation processes is determined by the nature and risk of the restraint being used and the needs of the resident.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service conducts comprehensive restraint use reviews to determine any trends, adverse outcomes and progress in reducing restraint. Internal restraint audits are conducted by the systems auditor/quality manager and results and restraint statistics are discussed in staff quality meeting. The sampled resident's care plan identified alternative techniques to restraint. The service is compliant with the policies and procedures. Interviewed staff demonstrated knowledge on the restraint monitoring requirements. Restraint training is completed annually for all staff, training records sighted.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	Indications for per rising need (PRN) medication are clearly documented on the prescription charts. All medication given is signed for on medication signing sheets sampled. Residents and or family are advised of any medication changes and appropriate documentation was sighted in residents' progress notes in sampled files. Interviewed family members confirmed that they are advised of any medication changes. The PRN medication administered to residents are not monitored for effectiveness and the GP is not recording the stop date for short term medication prescribed.	The medicine management information recording does not comply with current medication legislation and guidelines.	To ensure PRN medication administered is monitored for effectiveness and GP documents the stop date for short term course medication. 180 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, 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.