

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 BSI Group New Zealand Ltd, 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 - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 February 2021 End date: 10 February 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	97

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

WesleyCare is governed by the Christchurch Methodist Mission board. WesleyCare 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 97 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 practitioners.

The care services manager has been in her role since June 2019. She is supported by a quality manager, a business and operations manager, a clinical manager, and two-unit coordinators. Residents, relatives and the general practitioners interviewed were very complimentary of the services and care provided.

This audit identified improvements required around quality goal reviews, satisfaction surveys, interRAI assessments and interventions, and food storage.

Consumer rights

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes detailed information about the Code including (but not limited to) the complaints process. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Māori cultural links are in place with Ngai Tahu. Discussions with residents and relatives confirmed that residents and (where appropriate) their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health.

There is an established system for the management of complaints.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Services are planned, coordinated, and appropriate to the needs of the residents. The management team (care services manager, quality manager, clinical manager, business operations manager and two-unit coordinators) are responsible for the day-to-day operations of the facility. Quality goals are documented for the service.

A quality and risk management system that supports the provision of clinical care is established. Adverse event data is analysed and reported in the facility (quality) meetings. Interviews with staff and review of meeting minutes reflect a culture of quality improvements.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff that is specific to the job role and responsibilities of the position. Ongoing education and training for staff is being implemented.

The staffing levels meet contractual requirements. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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An information pack is available prior to or on entry to the service. Registered nurses' complete initial assessments including interRAI assessments, care plans and evaluations. Care plans are integrated and include the involvement of allied health professionals. Residents and relatives interviewed confirmed they were involved in the care planning and review process. General practitioners review residents at least three monthly or more frequently if needed.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting and includes outings, entertainers and community interactions. The programme caters for the individual needs of residents and involves community activity.

Medicines are stored and managed appropriately in line with legislation and guidelines. Registered nurses and senior healthcare assistants administering medications have completed annual competencies. The general practitioners reviewed the medication charts at least three-monthly.

Meals are prepared and cooked on site. The menus are reviewed by a dietitian. The menu is varied and provides meal options. Individual and special dietary needs are catered for. Residents interviewed were very complimentary about the food service.

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 building has a current warrant of fitness. All rooms are single, personalised and have ensuite facilities. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activities. The dining and lounge seating placement encourages social interaction. Outdoor areas are safe and accessible and provide seating and shade for residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely, and the laundry is well equipped. The cleaning service maintains a tidy, clean environment. Emergency and security systems are being implemented, an emergency evacuation plan in place and sufficient civil defence supplies. There is a first aid trained staff member on duty at all times.

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 seven residents requiring restraints and nine residents using enablers at the time of the audit. The service evaluates the resident's use of restraint three-monthly (at a minimum). Staff receive regular training and education on 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 is led by a registered nurse, who is supported by the quality (management team). The infection control policies and procedures, and the pandemic plan have been updated to reflect current best practice and Covid-19.

The infection control programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the infection control nurse management and the quality team. Staff are informed about infection control practises through meetings, training and information posted up on staff noticeboards.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information

used to identify opportunities for improvements. Infection control data is benchmarked within the electronic system. Covid-19 was well prepared for, an infection control room has been maintained with isolation grab and go kits. Adequate supplies of personal protective equipment were sighted during the audit. There have been no outbreaks 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	45	0	3	2	0	0
Criteria	0	96	0	3	2	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>A policy relating to the Code is implemented. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families in the foyer. Interviews with six managers (one care services manager, one quality manager, one clinical manager, one business operations manager, two unit coordinators/registered nurses (RNs) and twenty-seven staff (two enrolled nurses (ENs), seven RNs, seven healthcare assistants (HCAs) (four AM shift and three PM shift), one chef and one cook, three activities staff, one maintenance manager and one maintenance person, one advocate, one housekeeper, two laundry staff) confirmed their familiarity with the Code. They were able to describe how the Code is incorporated into their job role and responsibilities. Staff receive training about the Code during their induction to the service and through the regular in-service education programme.</p>
<p>Standard 1.1.10: Informed Consent</p>	FA	<p>Resident admission agreements were signed in the ten (four rest home</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>		<p>and six hospital) resident files sampled. The admission form has an 'outing and indemnity consent and release' section for residents or enacted enduring powers of attorney (EPOA) to sign. All resident files reviewed also had appropriately signed informed consent, medical care guidance (ceiling of care) form and advanced directives were recorded. Nurses reported that relatives' 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. Progress notes and GP consultation notes evidence resident and relative (where appropriate) involvement in decision making.</p>
<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>	<p>FA</p>	<p>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 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 designated advocate is employed by the service who chairs the residents' meetings.</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>	<p>FA</p>	<p>Nurses reported that a resident drives his own car out and about, one resident goes to the RSA weekly, one rest home resident is very involved with her church in the community, the resident advocate takes residents out for shopping trips, and there are regular van outings. Entertainers visit the facility.</p> <p>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 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.</p> <p>There are a number of community visitors to the facility including primary school children, guest speakers and entertainers. Young</p>

		<p>persons with a disability are encouraged to maintain links with the community with examples provided (eg, one resident is an organiser of a local club with regular outings associated with this affiliation, lunches with friends, going outside for walks, going out for a coffee at the nearby Mitre 10).</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>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The care services manager leads the investigation of any concerns/complaints. Complaints are discussed at the monthly quality meetings and clinical meetings. Complaints forms are available and visible at the main entrance, adjacent to a suggestions box. One HDC complaint, received on 15 November 2019, remains open. All required evidence relating to this complaint has been submitted to HDC. A quality initiative developed as a result of this complaint has been around improving communication with families. The facility is awaiting further direction from HDC regarding this complaint.</p> <p>A complaints register is maintained. Eight complaints were received in 2020 and nil in 2021 (year to date). Complaints are managed appropriately. Timeframes for responding to each complaint meet guidelines determined by HDC. One 2020 complaint remains open, awaiting closure from the complainant and their family. Quality initiatives implemented relating to this complaint include ensuring families are made aware of assessments taking place with the needs assessor and ensuring staff do not take their phones to meetings. The remaining seven complaints are documented as resolved.</p> <p>Residents and families interviewed are aware of the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>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 care services manager, clinical manager and/or unit coordinator discuss aspects of the Code with residents and their family on admission. Interviews with five residents (four rest home and one hospital) and five relatives (two rest home and</p>

		three hospital) confirmed that the residents' rights were being upheld by the service.
<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>Healthcare assistants interviewed reported that they knock on bedroom doors prior to entering rooms. This was observed during this two-day 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 are respected. The residents' personal belongings are respected. Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The 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 healthcare assistants interviewed reported that they value and encourage active participation and input from whānau in the day-to-day care for any residents who identify as Māori. The service has a long-term relationship with the iwi Ngai Tahu and have access to onsite Māori support through the Mission. A tikanga Māori guide is available for staff to read. Staff are provided with regular te reo Māori classes. Resident rooms are blessed following a death.</p> <p>There were no residents who identified as Māori on the day of audit. A Māori health assessment/plan is available for any resident who identifies as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>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.</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>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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There is an RN on duty 24 hours a day and an RN available on call for additional support as required. Healthcare assistants confirmed on interview that they feel supported and that their contribution towards residents' cares is valued. Policies and procedures, purchased by an external consultant, are regularly reviewed. Staff are required to read any new or updated policies. Residents and family interviewed reported that they are satisfied with the services received although a satisfaction survey has not been conducted since 2018 (link 1.2.3.6). There are a range of health professionals involved in the residents' cares including a general practitioner, physiotherapist and dietitian. Three general practitioners from one medical centre are on site three days a week with on call services 24/7. Physiotherapy services are available twice per week (eight hours). Two physiotherapy assistants help to carry out physiotherapy plans. Residents are regularly monitored for weight loss. If the resident experiences a weight loss of 3% or higher, a referral is made to a dietitian who visits the facility on a monthly basis. Church services are offered in the chapel twice per week with a chaplain readily available 24/7.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The care services manager operates an open-door policy. Fifteen incident/accident forms reviewed for 2020/21 identified that family are notified following a resident incident. Family members interviewed confirmed that they are notified promptly of any incidents/accidents. There is a resident advocate who is readily available and who chairs the regular resident meetings. A resident meeting was observed</p>

		<p>during the audit. It was well attended (24 residents) with evidence of open communication from the residents and advocate.</p> <p>Interpreter services are available if required. All residents at the time of the audit were able to speak and understand English. Residents interviewed stated they are all kept well informed.</p> <p>Residents and family interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry.</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>PA Low</p>	<p>WesleyCare is governed by the Christchurch Methodist Mission board. This aged care service is one of five divisions. The Mission has an overarching strategic plan for 2019-2021 that includes their mission and values. There are also specific goals for the aged care service that are described in the 2017-2019 and the 2020 quality plans but these goals do not reflect evidence of regular reviews. The care services manager is currently in the process of developing goals for 2021.</p> <p>WesleyCare provides care for up to 108 residents at hospital (geriatric and medical) and rest home levels of care. On the day of the audit, there were 97 residents – 23 residents at rest home level and 74 at hospital level. Four hospital level residents were on a younger person with disability (YPD) contract, two hospital level residents were on an end of life (EOL) contract, and one hospital level resident was on a serious medical illness (SMI) contract. The remaining residents were on the aged residential care services contract (ARC).</p> <p>The care services manager of WesleyCare has been in her role since June 2019. She is an RN with 15 years of experience as a facility manager in aged care. The care services manager is supported by a management team (quality manager/RN who works three days a week, a clinical manager/RN who works three days a week, a full-time business operations manager who oversees the non-clinical services (eg, kitchen, cleaning, laundry, maintenance) and two-unit coordinators/RNs).</p> <p>The care services manager has completed a minimum of eight hours</p>

		of professional development relating to managing a rest home and hospital facility.
<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>	FA	<p>The care services manager is an RN who in her absence is supported by the part-time (three days a week) clinical manager/RN and part time (three days a week) quality manager/RN. The quality manager and clinical manager would ensure that they were scheduled to have a least one of them available Monday – Friday if the care services manager was on leave.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>The quality and risk management policies and procedures describe the facility's quality improvement processes. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly by an aged care consultant who is contracted to the service.</p> <p>Discussions with registered nurses and healthcare assistants (HCAs) confirmed their involvement in the quality programme. Adverse event data is entered into an electronic data base and benchmarked against industry standards. Internal audits have been completed as per the internal audit schedule. Meeting minutes evidence discussion around adverse event data and trends but were missing detail around internal audit results and corrective actions (if any).</p> <p>Resident/relative satisfaction surveys were completed in 2017 and 2018 but have not been repeated since 2018. This gap was also identified during the previous surveillance audit. The quality manager stated that surveys will be delivered to residents and families later this month. The residents and relatives interviewed are satisfied with the services received.</p> <p>There is a risk management plan in place. The quality manager attends monthly health and safety meetings for the Mission on behalf of the aged care facility. Staff have access to an employee assistance programme. The care services manager is the health and safety officer for the facility. Staff receive health and safety training during orientation and ongoing. Actual and potential risks are documented on</p>

		<p>the hazard register, which identifies risk ratings, controls and frequency of monitoring. The hazard register is regularly reviewed. Contractors are orientated to health and safety processes via the maintenance staff.</p> <p>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. Physiotherapy assessments and reviews are completed post falls (as requested). Staff attend safe manual handling sessions.</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>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident and entered into the electronic system for benchmarking. There are documented and timely RN assessments for accidents/incidents. Incident/accident data is linked to the organisation's quality and risk management programme. A report is presented each month at the quality meeting including trending and analysis of falls and infections.</p> <p>Fifteen accident/incident forms were reviewed (2020 and 2021) including falls (witnessed and unwitnessed), pressure injuries, and skin tears. Each incident included a resident clinical assessment and follow-up by a registered nurse. Neurological observations were conducted for unwitnessed falls and where there was an obvious or suspected knock to the head.</p> <p>Section 31 notifications have been completed for pressure injuries and a change in the care services manager.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place which include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. A register of current practising certificates is maintained. Thirteen staff files reviewed (three healthcare assistants, four staff RNs, one cook, two kitchenhands, one fluid assistant, one cleaner, and one service worker) evidenced that reference checks are completed</p>

		<p>before employment is offered. Also sighted were signed employment agreements and job descriptions.</p> <p>The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. The orientation programme is specific to the job role and responsibilities. The education programme being implemented includes in-service training, competency assessments, and impromptu (toolbox) talks. Healthcare assistants are encouraged to complete an aged care education programme that meets the New Zealand Quality Authority (NZQSA) requirements. In-service training covers topics relating to young persons with a disability (eg, privacy, community, socialisation).</p> <p>Sixteen of eighteen RNs (including two-unit coordinators) have completed their interRAI training. A first aid trained staff member is always present on site and on activity outings.</p> <p>In-house chemical safety training for staff who handle chemicals is completed by Ecolab on a six-monthly schedule.</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>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.</p> <p>The care services manager (Monday – Friday) and clinical manager (three days a week) provide on-call cover. The quality manager/RN also works three days a week. Two-unit coordinators/RNs are employed, one for the ground floor (Tawa and Karaka wings) and one for the first level (Whero and Kanurangi wings). Beds throughout the facility all dual-purpose.</p> <p>Tawa wing (fourteen rest home and fifteen hospital): One RN covers the AM and PM shifts, and one RN covers the entire ground floor during the night shift. Four long and two short shift (0700-1300) healthcare assistants (HCAs) cover the AM shift, three long and two short shift (1700-2100) HCAs cover the PM shift, and three HCAs are</p>

		<p>rostered for the ground floor during the night shift.</p> <p>Karaka wing (four rest home and nineteen hospital): One RN covers the AM and PM shifts. Three long and two short shift (0700-1300) HCAs cover the AM shift, three long and one short shift (1700-2100) HCAs cover the PM shift.</p> <p>Whero wing (three rest home and twenty hospital): One RN covers the AM and PM shifts, and one RN covers the entire first floor during the night shift. Four long and one short shift (0700-1300) HCAs cover the AM shift, three long and one short shift (1700-2100) HCAs cover the PM shift, and three HCAs are rostered for the entire first floor during the night shift.</p> <p>Kahurangi wing (two rest home and twenty hospital): One RN covers the AM and PM shifts. Three long and two short shift (0700-1300) HCAs cover the AM shift, three long and one short shift (1700-2100) HCAs cover the PM shift.</p> <p>In addition, there are two 'pool shift' RNs who cover either an AM or a PM shift four days a week and five days a week (guaranteed hours). Two pool shift HCAs are rostered with one for the AM shift and one for the PM shift (guaranteed hours). Agency staff are used as needed.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>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. Accident/incident forms are held in hard copy in a separate folder (by month and year) and can be linked back to the hard copy resident file. Plans are progressing to transition to electronic residents' files. Entries are legible, dated, timed and identifiable, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p>	FA	<p>WesleyCare has a comprehensive admission policy. Admission</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>		<p>agreements reviewed were signed and aligned with contractual requirements. Exclusions from the service are included in the admission agreement. An admission pack relating to the services provided at WesleyCare is available for families and residents prior to admission or on entry to the service.</p> <p>Residents on the aged care contract have interRAI assessments completed by the needs assessment team prior to admission to determine level of care and needs of the resident. Residents and/or relatives are provided with information in relation to the service. Residents on other contracts have completed assessments and approval prior to admission to WesleyCare. Information gathered at admission is retained in the residents' records. The residents and relatives interviewed stated they were well informed upon admission.</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>	<p>FA</p>	<p>Policies and procedures are in place to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. Planned exits, discharges or transfers were coordinated in collaboration with the resident and relatives to ensure continuity of care. The registered nurses interviewed described using the 'yellow envelope' method for planned transfers to hospital. There was evidence that residents and their relatives were involved for all exits or discharges to and from the service.</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>	<p>FA</p>	<p>Policies and procedures are in place for safe medicine management. Medications are stored safely in the medication rooms on each floor. Registered nurses, enrolled nurses, and medication competent healthcare assistants administer medications. These staff have been assessed for competency on an annual basis and attend annual medication education. Registered nurses have completed syringe driver training. All medication blister packs are checked on delivery against the electronic medication charts.</p> <p>Twenty electronic medication charts were reviewed and met prescribing requirements. Medication charts had photo identification and allergy status notified. The GP had reviewed the medication</p>

		<p>charts three monthly. 'As required' medications had prescribed indications for use. There were five resident's (four rest home and one hospital) self-administering medication on the day of the audit. Policies and procedures for residents self-administering are in place and this includes ensuring residents are competent and safe storage of the medications. There are locked drawers available in each resident room.</p> <p>The medication fridges are checked as per policy, and temperatures are maintained within the acceptable temperature range. Medication room temperatures were checked and recorded. An air conditioning unit ensures medication rooms are maintained within expected ranges. All eye drops sighted in the medication trolleys were dated on opening.</p>
<p>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.</p>	<p>PA Low</p>	<p>WesleyCare has one large well-equipped kitchen on the ground floor and a satellite kitchen on the first floor. The food services team is overseen by the business operations manager. There are four qualified chefs, one baker and four kitchenhands on duty each day. Kitchenhands are responsible for washing dishes and maintaining cleaning duties as scheduled. A current food control plan is in place expiring on 25 September 2021.</p> <p>The five weekly seasonal menus are designed by a dietitian. All meals are prepared in the main kitchen and served from the kitchen directly to the residents in the main dining room on the ground floor. Food is transferred to the satellite kitchen via the 'dumb waiter' lift and served by a cook to the residents via the servery. Meals are plated in the main kitchen and transported to resident rooms by hot boxes. All food temperatures (on entry delivery and cooked), hot box temperatures and bain marie temperatures are recorded and within acceptable ranges. All fridges, chillers and dining room fridge temperatures are checked, recorded and within expected ranges. Cleaning schedules are maintained. The food in the fridges was covered and dated, the pantry evidenced good stock rotation. Herbs and spices are decanted into sealed containers, however, not all of the decanted spices and herbs have expiry dates indicated on the containers.</p> <p>Diets are modified as required. The chef and the cook interviewed</p>

		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. Residents and relatives interviewed were complimentary of the food services.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry is declined.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Registered nurses complete an admission assessment including relevant risk assessment tools. Risk assessments are completed six-monthly or earlier due to health changes. InterRAI assessments and long-term care plans were documented, however not always within expected timeframes (link 1.3.3.3). Outcomes of assessments are reflected in the needs and supports documented in the care plans on the care plans. Other available information such as discharge summaries, medical and allied health notes and consultation with resident/relative or significant others are included in the long-term care plans.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	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 always reflect the residents' current needs, or non-pharmaceutical interventions to be considered. Short-term care plans were in use for changes in health status.; however, not all documented nursing interventions to support current assessed needs. Resident files reviewed identified that family were involved as documented in the family/whānau contact sheet.

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met and stated they are notified of all changes to health as evidenced in the progress notes. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or referral to nurse specialist consultants occurs.</p> <p>Care plans reflected the required health monitoring interventions for individual residents. The short-term care needs were integrated into the long-term plan. Short-term care plans were sighted for infections, unintentional weight loss, and wounds.</p> <p>There was a total of 30 wounds throughout the facility on the days of the audit. These included cancer lesions, skin tears, chronic ulcers, and surgical wounds. There was one healing unstageable pressure injury (section 31 was completed), one stage 1 and one superficial stage 2 pressure injuries. Incident reports had been completed for all pressure injuries, and injury related wounds. All wounds had individual assessments, management plans and evaluations. Photographs were taken regularly to evidence progression and deterioration of the wound. The GPs are involved with clinical input for wounds and pressure injuries and the wound care specialist nurse is accessed as required. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury. Staff have received training on pressure injury prevention and wound cares.</p> <p>Healthcare assistants and enrolled nurses interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. A continence specialist can be accessed as required.</p> <p>Monitoring charts included (but not limited to); weights, observations, blood glucose monitoring, behaviours, restraint/enablers, repositioning, fluid balance, and hearing aid checks.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs,</p>	<p>FA</p>	<p>There are two diversional therapists, one activities assistant and one residents' advocate that provide a combined activity programme over five days each week with a weekly programme that covers both floors.</p>

<p>age, culture, and the setting of the service.</p>	<p>All of the activities team have a current first aid certificate.</p> <p>A diversional therapy plan was in place for each resident which incorporates the information provided by the resident and relatives around previous likes, hobbies and interests. The activities team document an evaluation of the plan at least six-monthly, and as changes arise. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The programme is planned weekly, and residents receive a copy of the planner to display in their rooms. There are combined activities where residents from upstairs go downstairs and vice versa as observed during the audit. The activities team report making more use of the outside areas, residents who are interested in gardening have been growing vegetables and flowers. The excess vegetables that have been grown have been sold with the proceeds going back into improving the garden. The kitchen has been using the herbs. The activities team are planning to assist the residents to preserve the fruit from the trees. The garden has become a talking point, especially during one-on-one sessions. The brass band has played in the courtyard, so all residents can see and hear them from all around the facility. A current initiative is to extend the activities for the gentlemen in the facility.</p> <p>The service has a van and a car that is used for resident outings and appointments. The activities team reported they are in the process of reintroducing outings again post Covid-19 mainly due to the increasing frailty of the residents.</p> <p>The three-monthly resident meetings (chaired by the resident's advocate) provided a forum for feedback relating to activities (as witnessed during the audit). Relatives interviewed commented there was always something going on for residents to participate in.</p> <p>Activities for younger people included attending groups previously attended, crafts such as beading, and shopping trips. All residents are provided with the planner and offered to attend the activities on offer. The activities team reported one younger resident especially enjoys the newspaper reading and discussion around current affairs. Another resident is very involved with their church and one resident attends the muscular dystrophy group. When residents are on palliative care, the activity team visit these residents and participate in one-on-one</p>
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		activities as guided by the resident.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The evaluation and care plan review policy require that long-term care plans are reviewed six-monthly, or as residents' condition changes. Any changes to the long-term care plan were dated and signed by the registered nurse. 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. Progress notes were comprehensive, and evidenced follow-up by RN when resident condition changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral to other health and disability services is evident in the sample group of resident files. Referral documentation is maintained on resident files. Discussions with the clinical manager, unit coordinators and registered nurses identified that the service has access to specialist nursing services such as the dietitian, speech and language therapists, continence nurses, mental health nurse practitioner, palliative care services and wound specialist nurses.</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>There are policies around waste management, chemical use and storage, and storage and waste policies in place. Material safety datasheets are available in the sluice rooms and the laundry. Personal protective equipment including gloves, aprons and goggles are available for staff throughout facility. There is a sluice room on each floor. The sluice rooms are secure with a keypad entry. The laundry is locked when staff are not in the laundry. The cleaning trolley is locked away when not in use. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Laundry and housekeeping staff stated they have completed an education session on chemical safety. The clinical staff interviewed were knowledgeable around the management of infectious waste and described training sessions around donning and doffing personal protective equipment.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>WesleyCare has a current building warrant of fitness expiring on 1 January 2022. Electrical equipment has been checked and calibrated annually (next due June 2021). Reactive and preventative maintenance occurs. The maintenance manager and a maintenance person were interviewed. They demonstrated the electronic maintenance schedules, and hot water monitoring. The hot water temperatures reviewed were all within expected ranges. A maintenance book is at reception for staff to report breakages. This is checked regularly throughout the day.</p> <p>Both floors have large open plan lounge/dining areas. The upstairs lounge has full height windows and doors which provides access to the balcony. The upstairs balcony area, the way the facility is built, and planting provides shade and seating is provided for residents and visitors to enjoy. There are smaller, quieter lounges for residents and visitors. The external garden areas are well maintained and are easily accessible for residents requiring mobility aids.</p> <p>The service has a van and a car used for transporting residents, both with current warrant of fitness and registration.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All resident rooms are ensuited. There are also adequate toilet facilities for use by staff and visitors. Communal toilets and bathrooms have appropriate signage and shower curtains installed. All toilets and bathrooms have red/green indicators and privacy locks.</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>The rooms are spacious and provide adequate space for equipment to be manoeuvred around the bed and personal space, for those indicated. Healthcare assistants interviewed reported that rooms have sufficient space to allow care to take place. Residents interviewed voiced their satisfaction with the size of their bedrooms and have the freedom to bring in their own belongings and trinkets.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Both floors have large open plan dining/lounge areas which are used for activities and large gatherings. Furniture is arranged to maximise free mobility for all residents. Smaller seating areas are available including a whānau room. All communal areas are easily accessible for residents using mobility aids.</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>There are laundry and cleaning policies and procedures. There are dedicated housekeeping and laundry staff. All laundry is done on site. The laundry has a clear dirty to clean flow. The two laundry assistants interviewed described the closed chemical system, data sheets and personal protective equipment available. The laundry was well organised, tidy and free of hazards. The laundry assistants described chemical safety, health and safety and hazard training. The laundry is locked when not in use.</p> <p>The cleaner's trolley is locked away when not in use. All chemicals on the cleaner's trolley were labelled and were in original containers. There is an internal audit around laundry services and environmental cleaning completed as part of the internal audit schedule. The housekeeper interviewed has completed chemical training and was knowledgeable around infection control processes. The residents and relatives interviewed were satisfied with the laundry and housekeeping services.</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>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 is implemented. 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 for each shift and on outings.</p> <p>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</p>

		rooms, toilets and communal areas have call bells. Residents were observed to have their call bells in close proximity. Residents are also given the option of wearing a call bell pendant.
<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	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. Large windows provide natural light in resident's rooms.
<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 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. The infection control room is centrally located and has stores 'grab and go' isolation kits, and stores of personal protective equipment. Adequate supplies of personal protective equipment were sighted. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.</p> <p>The service has maintained contact tracing for all visitors and contractors entering the facility. There are hand gels available in the corridors for residents and visitors to use.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control nurse provides an infection report to the quality/staff and registered nurse meetings.</p> <p>The IC coordinator has attended infection control education and can access the district health board (DHB) infection control specialist, Southern Laboratory microbiologist, GPs and public health advice when required. The infection control coordinator described utilising the Altura online training, health-learn (online) and MOH sites.</p> <p>Covid-19 was well prepared for. Policies procedures and the</p>

		<p>pandemic plan have been updated to guide staff around the management of Covid-19. There were no recommendations following the DHB Covid-19 audit. All staff signed they had read the updated policies. Staff interviewed were well versed on the procedures around Covid-19.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>WesleyCare has a suite of infection control policies and an infection control manual provided through an external provider. Policies and procedures reflect current practise and have been regularly reviewed. Policies, procedures and the pandemic plan have been updated to include Covid-19.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>All new staff receive infection control education at orientation, including hand washing and an infection control questionnaire. Infection control education is included in the annual education planner. Additional tool-box talks are provided as infection control issues arise. Extra training was provided for Covid-19 preparations including (but not limited to); around donning and doffing personal protective equipment, isolation techniques and hand hygiene competencies were reviewed.</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>Infection monitoring is the responsibility of the infection control nurse with support from the quality manager. All infections are entered into the electronic database, which generates a monthly analysis of the data. There is an end of month analysis with any trends identified and corrective actions for infection events above the industry key performance indicators. There are monthly comparisons of data. The quality manager provides graphs and pie charts from the electronic system. The results are benchmarked using the electronic system. These are displayed in the staff room for staff to read and discussed at the meetings in the facility.</p> <p>Short-term care plans were sighted for all residents with a current infection. There was a suspected outbreak in October 2020, which</p>

		was well documented and well managed. The results of samples sent to the laboratory were negative. The service worked alongside the public health team until the negative result. There have been no other outbreaks since the previous audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The service is committed to restraint minimisation, and safe practice was evidenced in the restraint policy and by interviews with clinical staff. At the time of the audit there were seven hospital level residents using a restraint (bed rails and lab belts) and nine hospital level residents using an enabler (safety belts and bed rails). There is evidence of alternatives to restraint considered, and relative's involvement prior to restraint. The use of enablers is voluntary and requested by the resident. Staff receive regular training on the use of restraint and enablers that begins during their orientation.
<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	The restraint coordinators are the two-unit coordinators, one on each of the two floors. Assessment and approval processes for a restraint intervention include the restraint coordinator/RN, resident/or representative and medical practitioner.
<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	The service completes assessments for residents who require restraint or enabler interventions. These are undertaken by the restraint coordinators in partnership with the family/whānau. Two resident files where restraints were in use (lap belts) and one resident file where an enabler was in use (lap belt) were randomly selected for review. Assessments and consents were completed for all three files. The resident signed for consent for voluntary use of the enabler and family signed for consent for the two restraints.
<p>Standard 2.2.3: Safe Restraint Use</p>	FA	A restraint register is implemented for each floor and is kept up to date by each of the restraint coordinators. The restraint minimisation

<p>Services use restraint safely</p>		<p>policies and procedures identify that restraint is only put in place where it was clinically indicated and justified and approval processes. The care plans for the files reviewed described the restraint or enabler intervention, including risks associated with the restraint. Monitoring forms reflect regular two hourly monitoring (or more frequent) of the restraint or enabler.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Evaluation timeframes are determined by risk levels but at least every three months, sighted in all three files reviewed. Restraint practices are also reviewed on a formal basis every month by the restraint coordinators at the quality meeting and at the three-monthly restraint meeting. Adverse outcomes (if any) would be reported at the monthly quality meetings.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews the restraint programme as part of the internal audit and reporting cycle, and staff education review.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	An overarching strategic plan is developed for the organisation. In addition, a quality plan is developed for the facility that lists business goals and objectives.	Goals for the facility are documented. Goals documented for 2020 are scheduled to be reviewed this month as an end of year responsibility. Goals documented for the previous year (2019) do not show evidence of any reviews.	<p>Ensure that facility goals are regularly reviewed, not only at year end.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	Quality data collected includes data from internal audits and adverse events. Adverse event data is shared with staff in the quality meetings but internal audit results, and any relevant corrective actions are not. Staff are able to read the meeting minutes, which are posted in the staffroom. Meeting minutes have recently begun being sent via email to staff.	<p>i) At the last (surveillance) audit 18 months prior to this audit, it was reported that a satisfaction survey was being planned. This survey has not taken place yet. The quality manager stated a resident/family satisfaction survey will be conducted later this month.</p> <p>ii) There was a lack of evidence to</p>	<p>i) Ensure resident and family satisfaction surveys occur on a regular basis.</p> <p>ii) Ensure staff are informed of quality results, including internal audit results and corrective actions (where applicable).</p>

			indicate that staff are informed of internal audit results and corrective actions (where applicable).	90 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	A current food control plan is in place. All cleaning schedules are maintained. Fridge temperatures and food temperatures are recorded and are within ranges. The pantry is well stocked, and the chef described food rotation including the emergency food stocks, however, not all dry food decanted into sealed containers have expiry dates displayed.	The dry food decanted into sealed containers did not identify expiry dates.	<p>Ensure all containers storing decanted food displays the expiry date.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	PA Moderate	Risk assessments including (but not limited to) falls risk, pressure risk, continence, and clinical risk forms were completed on admission to the facility for each resident and at least six-monthly. InterRAI assessments were in place for the resident files reviewed, however, these were not always completed within expected timeframes. The resident files reviewed had a long-term care plan in place, however, these were not always completed or reviewed within expected timeframes.	<p>(i) One hospital resident on an SMI contract did not have a long-term care plan completed within three-weeks of admission.</p> <p>(ii) One hospital level resident did not have a care plan review completed within six-months.</p> <p>(iii) One hospital and four rest home residents did not have an interRAI assessment completed or reviewed within expected timeframes.</p>	<p>(i) Ensure all initial care plans are complete within three weeks of admission.</p> <p>(ii) Ensure all care plans are reviewed at least six-monthly.</p> <p>(iii) Ensure interRAI assessments are completed and reviewed within expected timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired</p>	PA Moderate	The long-term care plans included resident goals. Short-term care plans were in place for acute needs, and these had been reviewed regularly and either resolved or transferred to the long-term care plan	<p>(i). The long-term care plan did not reflect the current mobility interventions of a hospital resident.</p> <p>(ii). There were no individualised de-escalation techniques</p>	(i)-(iii) Ensure all care plan interventions are individualised, reflect resident current needs, and are holistic including

<p>outcomes identified by the ongoing assessment process.</p>		<p>interventions, however not all care plans reflected the current needs of residents, and non-pharmaceutical interventions were not always identified.</p>	<p>documented for a rest home resident with challenging behaviour.</p> <p>(iii). There were no non-pharmaceutical interventions included in the care plan for a hospital resident with chronic pain.</p>	<p>utilising non-pharmaceutical nursing interventions.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.