

# Maniototo Health Services Limited - Maniototo Health Service

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## 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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Maniototo Health Services Limited
<b>Premises audited:</b>	Maniototo Health Services
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 6 April 2021      End date: 8 April 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	27

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Maniototo Health Services Limited is a non-for-profit integrated hospital, rest home and community health centre based in Ranfurly, Central Otago district.

The facility provides hospital and rest home services for up to 31 residents, including 6 acute hospital medical beds. Occupancy at the time of audit consisted of 25 residents (13 hospital and 12 rest home), and 2 medical acute inpatients.

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

Areas identified as requiring improvement relate to: documentation of corrective action plans; documentation of a job description for the acting activities coordinator; and implementation of the preventative maintenance schedule.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaint process and the Nationwide Health and Disability Advocacy Service are accessible in the facility. This information is explained to residents and family/whānau on admission to the service.

Interviews with staff demonstrated an understanding of their responsibilities in upholding consumer's rights. Interviews with residents and family confirmed that staff are considerate and respectful of their needs, and that communication is appropriate and promotes open disclosure.

Residents' cultural, spiritual needs, values and beliefs are assessed on admission and embedded in care plans. The facility has linkages with specialist health care providers to support best practice and meet residents' service needs, including with a contracted aged care nurse consultant and with the district health board.

Informed consent is gained and documented, and advance directives are implemented as required. The general manager is responsible for the management of complaints. The complaints processes meet legislated requirements. The complaint register is up to date.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Maniototo Health Services Limited is governed by a board of six elected members. The company strategy is implemented through a biennial plan. A general manager, assisted by two clinical nurse managers and a quality improvement facilitator, is responsible for the strategic management of the hospital/rest home and the oversight of day to day operations. The two clinical nurse managers share responsibility for the coordination of resident and inpatient care. They are supported by a team of registered nurses, enrolled nurses and care givers who cover the service delivery 24 hours a day, 7 days a week, and as per contractual requirements. Medical services are available 24/7 through general practitioners and primary response in medical emergencies nurses.

All managers have relevant qualification and experience for their roles.

The service has a documented quality and risk management framework to guide practice.

The organisation has a documented quality and risk management system that supports the provision of clinical care and service improvement. Data is analysed and evaluated. Risks are identified and managed. Quality and risk outcomes are communicated to staff.

Professional qualifications are validated for staff who require them. Staff orientation and professional development is provided and relevant to service delivery. There is a system in place to manage annual staff education and competencies.

Service provider availability is managed through a staffing roster that considers skill mixes, occupancy and acuity of residents. Review of rosters and residents, family and staff interviews evidenced that services are provided that meet residents' needs.

Patients' information is recorded in a timely manner. All patient information is maintained in secured files and environment with no public access.

## 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.		Standards applicable to this service fully attained.
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Processes for entry and assessment for residential care and acute medical services are developed, implemented, and documented.

Residents/patients clinical records evidence assessments, care planning and care evaluations are undertaken in a timely manner. Care and treatment are documented by members of the multidisciplinary team. Residents/patients, enduring power of attorney and/or family have input into assessments, care planning and evaluations of progress.

Daily medical rounds for acute medical patients include planning for discharge or referral to other services. There is timely access to allied health services. An activities programme is provided for rest home and hospital residents.

Medicine management policies are in place. Staff who administer medications have current medication competencies. There were no residents self-administering medicines at the facility on audit days.

The food service is provided by an external contractor. The menu has been reviewed by a dietitian. The kitchen staff have completed food safety training.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The service has fully migrated to a newly built premises. A current certificate of public use was displayed. A reactive maintenance programme is implemented.

There are documented and implemented policies and procedures for management of waste and hazardous substances. The cleaning and laundry services follow documented schedules and good practice and are regularly audited by the facility.

The hospital and rest home environments are modern and appropriate to the needs of residents and medical inpatients.

Essential emergency and security systems are documented and implemented, with six-monthly trial fire evacuations undertaken. Call bells allow patients to access help in a timely manner on observations and interviews. All staff are trained in emergencies, with some staff trained in acute/advanced emergency response.

Protective personal equipment is available and observed to be utilised 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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Policies and procedure documents are current and available to all staff. There were four residents using restraints and no enablers in use during the audit period. Staff education in restraint, de-escalation techniques and managing challenging behaviour has been provided. The approval process for enabler use is activated when a patient or resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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There is an established infection prevention and control programme, and processes are in place to minimise infections. The programme is led by senior clinicians. Staff are educated and there are educational resources available for patients and residents. Surveillance data is collected, collated, analysed, and reported.



## 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)
<b>Standards</b>	0	47	0	3	0	0	0
<b>Criteria</b>	0	98	0	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Maniototo Health Services Limited (Maniototo) has a suite of policies and procedures to ensure the service is provided in a manner that is consistent with the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code).</p> <p>Staff receive education on the Code as part of their orientation and continuous education programme, which was evidenced through review of training logs and staff interviews. Staff and management interviewed demonstrated their understanding of the Code and their obligations to implement the consumers’ rights in practice, including but not limited to: supporting residents’ privacy; advocacy; and informed decisions.</p> <p>On observation, staff were respectful towards the residents and their family/whānau, and the service delivery was tailored to the needs of each individual. At interviews, residents and family/whānau confirmed that provided information and services are relevant to their needs and support their choices and decisions. They reported that cares are delivered in a manner that maintain their dignity, privacy, values and beliefs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their</p>	FA	<p>Maniototo has policies and procedures on informed and voluntary consent that align with Rights five, six, and seven of the Code regarding individual consent, competence, information, and treatment refusal or withdrawal. Information and competence assessments are included in the consent forms implemented by the facility.</p>

<p>family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>Staff receive orientation and training on informed consent, and staff interviews confirmed they are aware of the consent process and the requirement to provide enough information to support independent decisions. Informed consent processes are explained to residents and family/whānau on admission. Review of clinical documentation indicated that information is provided to residents and family/whānau, and consent is sought for all cares/treatments that are delivered. Long-term residents sign consent for their participation in outings, and the use of personal photographs. A room sharing agreement was sighted and signed by the two residents who shared a room.</p> <p>Residents who require this have a documented enduring power of attorney (EPOA) and recorded evidence of activation in relation to their finances and property, and/or personal care and wellbeing.</p> <p>Family interviews established that the service actively involves them in decisions that affect their relative's lives. Resident files of long-term residents have signed admission agreements.</p> <p>A policy is in place that provides guidance for advance care planning and resuscitation orders to be documented and acted upon when valid. Review of resident's notes and consent forms evidenced that the general practitioner (GP) provides the necessary information to residents and family/whānau to support do not resuscitate orders decisions. This includes discussion of resuscitation with the family/EPOA where the resident is deemed incompetent to make a decision.</p> <p>At interview, the GP confirmed understanding that resident competence and circumstances must be evaluated to implement advance directives. File reviews demonstrated that advance directives are completed and documented in accordance with regulatory requirements. Resuscitation orders are appropriately signed by the resident and/or GP.</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>Residents and family/whānau are informed of advocacy services accessible through the Health and Disability Commissioner (HDC) and the Nationwide Advocacy Services via: pamphlets and posters on display; resident/patient admission and service information; and information provided on the complaint process.</p> <p>Staff receive in-service education on the Code which includes advocacy, as stated by the CNMs and staff interviewed.</p> <p>Interviews with family/whānau, residents and staff confirmed that the service provides opportunities for a support person of their choice to be involved in discussions about patient treatment and care, and to be present during admission or resident stay.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other</p>	<p>FA</p>	<p>Interviews with residents, family and staff verified that residents have access to visitors of their choice at any time. Observations confirmed that family/whānau are welcome in the facility. Family are supported to take</p>

<p>Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>		<p>residents out in the community. Residents who can mobilise independently are encouraged to go out, for example with an electric scooter. Regular van trips are available to all residents, and the outing van is equipped with a functioning hoist to assist residents who require mobility help (refer to 1.4.2.4). Weekly trips to the hairdresser are organised for the residents who wish to access this service.</p> <p>Community (eg, library) and church services are brought to the facility to provide social support and entertainment. Some residents participate in art and craft classes in the community. Staff and managers interviewed reported that they encourage residents to maintain their usual social links and to use local community services.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A documented concerns/complaints policy outlines the organisation procedures to manage complaints that align with Right 10 of the Code. The policy applies to any expression of dissatisfaction communicated by a resident, a family/whānau, or a staff member. Written information on the complaint process, and complaint forms, are made available to residents and family/whānau on entry to the service. On observation, complaint information and complaint forms were also accessible in public and communal living areas throughout the facility. Information displayed includes: how to make a complaint; the management process and timeframes involved; the people responsible; and a list of available advocates.</p> <p>Residents and family interviewed confirmed that they are supported to give feedback and raise any concern on the services. Residents and family were aware of the complaints process and the option to make a complaint using a form, or directly to any staff member. At interview, staff described their responsibility to document and communicate received complaints to their manager.</p> <p>Minutes of residents' meetings evidenced that resident concerns constitute a planned item on the agenda, and that raised issues are discussed during meetings. Verbal feedback is collated for quality review and improvement. Individual feedback is addressed through the formal complaints process.</p> <p>A complaints register was reviewed that includes: the date the complaint is received; a description of the complaint; the investigation undertaken; the dates of communication of progress and resolution to the complainant; the complaint outcomes and sign off. Written communication to the complainant was consistently documented. The general manager (GM) is responsible for managing complaints.</p> <p>There had been six complaints reported on the register for the last eighteen months, including two verbal complaints. Review of documentation demonstrated that complaints are investigated promptly, and issues resolved in a timely manner. Two complaints addressed to the HDC had been closed off by the commissioner. Review of HDC communication indicated that in the first instance, the HDC had recommended to include verbal complaints in the facility policy documents and register, which had been satisfactorily achieved. In the second instance, Maniototo had been removed from a HDC complaint that related to another provider, following review of provided information. The GM interviewed reported that there had been no other complaint</p>

		to external agencies since the last surveillance audit.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Health and Disability Commissioner's pamphlets and posters on the Code were observed on display throughout the facility. Sighted pamphlets and information brochures are available at reception and provided to prospective residents and family/whānau or medical inpatients as part of their admission process and include: information on the Code; and information on how the facility supports consumers' rights during service delivery (eg, conditions to service access, support to residents' independence, visitors and complaints).</p> <p>The residents and family/whānau have opportunities to receive explanations or clarifications about their rights on admission or during pre-visits to the facility. The registered nurses (RNs) and clinical nurse managers (CNMs) interviewed were cognisant of their obligations to provide residents with information on their rights.</p> <p>Information on the Nationwide Health and Disability Advocacy Service is available in pamphlets within the facility. Right to advocacy and contact information for the Nationwide Health and Disability Advocacy Service are included in the complaint information on display in the different communal areas of the building, and this information is reiterated in the facility information packs. Residents' rights and advocacy are discussed at the residents' and family/whānau meetings (sighted minutes).</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>Maniototo has implemented policies and procedures that outline the obligations to respect the personal privacy of residents, their belongings, individuality, independence and dignity.</p> <p>Interviews with residents and observations confirmed that their privacy was respected. For example: permission was obtained from residents regarding visitors; staff announced themselves before entering private spaces; doors and curtains were shut when providing personal cares, clinical reviews or treatments were undertaken; and residents/inpatients were attired in a manner that respected their dignity. Although the nursing station had clear glass doors, confidential information about residents/inpatients was observed to be protected from public view. Interviews with staff confirmed that the confidentiality of resident information was maintained.</p> <p>Residents' and family' interviews verified that individual religious and social preferences, values and beliefs are identified and upheld. Individual needs and preferences of residents/inpatients, and strategies to support independence, were documented in reviewed assessments and care plans. Discussion relating to giving residents more choices regarding their clothing and grooming was documented in team meetings, care staff appraisals, and implemented. Interviews with the CNMs, staff, residents and family confirmed that residents/inpatients are supported to access services that are meaningful to them.</p> <p>An abuse and neglect policy states staff responsibilities for the identification, reporting, prevention and</p>

		<p>response to situations of abuse and neglect affecting residents. Policy includes referrals to external agencies, should this occur. Staff receive mandatory training on abuse and neglect. There was no reported incidence of abuse and neglect at the time of this audit, and this was confirmed in staff, residents' and family' interviews.</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>Maniototo has a Māori health and cultural safety policy which recognises the Treaty of Waitangi as foundation to services provided to Māori residents. The policy states the organisation commitments to: lifting barriers to service access for Māori residents; providing care according to te whare tapa wha model; and linking to Māori health advisers. The Maori plan execution was discussed with management and includes existing Maori representation on the governing board and partnerships with Māori communities through the district health board (DHB).</p> <p>Review of training logs and staff files evidenced that staff receive education on the Treaty of Waitangi and cultural safety as part of their orientation and ongoing education programme. Tikaka practice information was observed to be readily accessible at the nursing station. Interviews with managers and staff demonstrated knowledge of how to obtain guidance on culturally safe practices for Maori residents. Resident and whānau input, as well as Māori representatives available amongst staff or in the local communities would be used to provide advocacy for residents and to support culturally appropriate interventions, should this be needed.</p> <p>At interview, the CNM explained that there were no current residents who identified as Māori. Ethnicity and iwi connections are screened as part of the facility admission process, which was verified in the completed admission forms reviewed.</p> <p>Family/whānau are encouraged to attend care planning meetings and to support care throughout residents/medical inpatients stay. This includes supporting whānau to stay overnight with the resident/patient if they wish. A palliative care room is also available for end of life care residents where whānau can be accommodated.</p> <p>Documented policy and staff interviews evidenced awareness of the importance of involving whānau in the delivery of care. Family/whānau are for example invited to residents' meetings, and their active participation was evidenced in meeting minutes.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services</p>	FA	<p>Organisation policies on cultural safety, spirituality and counselling provides guidance to respond to the individual needs, values, and beliefs of residents and family/whānau during the planning and delivery of care. Public information on the service and staff interviews confirmed that the provider encourages residents/patients to express those needs on entry to the facility. Residents' needs were documented as part of the residents' reviewed assessments.</p> <p>Interviews with staff, residents and family evidenced that residents are provided with choices regarding their</p>

<p>which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>care, and that the delivered services meet their cultural and spiritual needs. Residents' lifestyle and activity plans were recorded and implemented to reflect individual preferences. Example of activities on offer included church services for different faiths, and war memorial services. The facility supports residents to move in with their pets when possible.</p> <p>Staff receive annual training in cultural and spiritual safety (sighted records and education programme). Staff interviewed demonstrated awareness of how culturally competent services should be delivered.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Maniototo staff are required to comply with organisation policies and a code of conduct which supports an environment free from discrimination, harassment, sexual and financial exploitation. Review of staff files indicated that the code of conduct is signed by employees as part of their contractual requirements.</p> <p>In interviews, staff acknowledged their obligations to treat patients regardless of their differences, and to report situations where patients are harassed or exploited should this occur. Residents and family' interviews verified that staff maintain appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Maniototo adheres to a suite of policies and procedures developed by an external health compliance system consultant. These documents reflect current legislation, standards and best practice guidelines, including national guidance and requirements from the Ministry of Health. Review of clinical policies and procedures confirmed they align with best practice. The service has a contract with the same consultant for the ongoing updating of policies, and when required is able to suggest enhancements to existing documents and procedures that arise from internal recommendations. Alternatively, the facility can develop and implement its own specific procedures and recording forms. Those processes were observed during audit.</p> <p>When necessary, the facility engages the services of clinical and multidisciplinary specialists from the DHB to support the cares of residents and acute medical inpatients.</p> <p>Staff and management interviews, and staff meeting minutes, indicated that service performance is regularly discussed with staff, along with strategies to improve outcomes. Residents' interviews, file notes and observations of resident care evidenced that good practice guidance is implemented.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	<p>FA</p>	<p>An open disclosure policy upholds the consumer's right to receive comprehensive information regarding untoward or adverse events. Interviews with staff confirmed an environment of open communication, where a 'no blame' culture supports the disclosure of untoward events to residents and family/whānau. Documentation relating to incidents and accidents demonstrated that relatives were notified of residents' incidents as</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>required.</p> <p>Multidisciplinary team meetings enable family to participate in care planning and are scheduled six-monthly or more often if needed. There was documented evidence of resident and family/whānau participation in multidisciplinary care planning. Interviews with family established that they receive regular updates on resident care progress.</p> <p>Sighted newsletters are sent to family/whānau with general updates on the facility events and services. Residents and family/whānau are provided with a list of key people to contact within the facility (sighted), would they have any questions or concerns. A RN is allocated to each resident for care planning and to ensure continuity of communication with the resident and their family/whānau.</p> <p>Access to independent interpreter services is available to residents and family through the DHB, and a list of local interpreters is provided. Interview with the CNMs indicated that staff and family can help translate if required. Language aids and visual aids (eg, large computer screens) are available to use with patients who experience communication barriers. Observed signs in residents' rooms alert care giving staff of residents' hearing difficulties or other communication requirements. The CNM interviews explained how they can involve occupational therapists and speech language therapists to support residents/patients with communication impairments, would this be required.</p> <p>At the time of audit there was no resident for whom English was not their first language.</p>
<p><b>Standard 1.2.1: Governance</b></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>Maniototo is a non-profit hospital and rest home that serves a regional community of more than 2,000 people situated between Middlemarch and Dunstan in Central Otago. The service business plans outline the organisation mission, objectives and values, which focus on rural community health services, professionalism, and responsiveness to the needs of the individuals. Values are shared with residents and family/whānau through facility communication.</p> <p>The organisation has a board of six elected members which provides strategic direction and governance to the service. A biennial business plan 2019-2021 is in place that documents current business and quality management objectives. The facility GM is responsible for the execution of the business plan.</p> <p>The GM has been in the role for over 14 years and has previous business management and financial experience through diverse organisations. The GM participates in regular meetings with other rural hospitals within the Central Otago region, and has close linkage with the DHB, ambulance and radiology services. The GM is updated on aged-care practice and service requirements through membership to national aged-care association and facility clinical leadership team.</p> <p>Two CNMs provide oversight for the clinical operations. One CNM has been working with the facility for thirty-six years, initially as an enrolled nurse (EN) and more recently as a RN) before taking on this leadership role</p>



		<p>three years ago. The other CNM has been working in the facility as a RN for four years before joining as a clinical leader three years ago; they have experience in acute medical/surgical/recovery care and are still practicing in critical care within public hospital. Both CNMs hold annual practicing certificates and primary response in medical emergency certificates.</p> <p>Maniototo delivers a variety of rest home services, hospital residential services, and hospital acute medical services, in addition to community services. There are 31 bed spaces available in the facility, including 6 identified bed spaces for acute medical inpatients that are grouped together in one area. Of the 31 beds spaces, 29 are suitable for residential care as dual purpose beds. Two bed spaces are included in a room used for acute emergencies and assessments that would be suitable for acute medical inpatients' short stay but would not be suitable for residential cares.</p> <p>At the time of the on-site audit, occupancy included 13 residents requiring hospital residential care, 12 residents requiring rest home care, and 2 inpatients requiring hospital acute medical care. The facility is divided into two wings. There was a mix of residential care residents, hospital and rest home, across the two wings. Acute medical inpatients were located in the dedicated acute medical area.</p> <p>The service holds current contracts with the DHB for: aged-related residential care; aged-related respite care; short-term palliative hospital level care; and rural hospital – medical and surgical services (sighted). It also has community health services head agreements, and contracts for domiciliary services; maternity resources centre; and well-child services for example. There was no young people with disabilities (YPD) who resided at the facility at the time of audit.</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>	FA	<p>In the temporary absence of the facility GM, one of the CNMs would be responsible for the day to day operation of the service. In the absence of one of the CNMs, the other CNM would carry on their duties with the support of the senior RNs within the facility. This was evidenced though staffing roster reviews, which demonstrated that when one CNM had been on annual leave, the other CNM had provided necessary cover.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	PA Low	<p>Maniototo has a documented quality assurance and risk management policy which proposes a framework for continuous quality improvement and risk management within the organisation. A quality programme is documented that includes: internal audits on key clinical and service performance indicators, and other quality assurance processes such as; the development of quality plans; education reviews; residents' surveys; health</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>and safety programmes; quality improvement projects; and special committees. Management and staff are committed to discuss aspects of quality outcomes and improvements at regular scheduled meetings. This was evidenced through meeting minutes and agendas, managers and staff interviews. A full time quality improvement facilitator has been recruited in June 2020 to support the development and implementation of quality processes within the facility.</p> <p>All sighted organisation policies showed evidence of current review and document control. Review of policies is contracted to a residential care nurse management consultant and occurs at least two-yearly, or more often if there is a change of practice or regulatory requirement. Policies are available to all staff electronically and in hard copy folders at the nursing station. Review of the folders evidenced that outdated documents had been removed from circulation. Policies and changes to policies are discussed in documented management and staff meetings, and as part of internal education. At interviews, staff demonstrated how policies' requirements are communicated to them.</p> <p>A documented internal audit programme is implemented as planned, which covers all aspects of clinical and non-clinical service delivery. Audit results are discussed by management and heads of department as part of quality reviews, alongside review of events, complaints, resident feedback, staffing/education, infection control, restraint, health and safety, and general business (sighted minutes).</p> <p>Quality improvement data on service delivery is monitored through the organisation's reporting systems that were reviewed, with a combination of automated electronic reporting, and manual reporting. Discussion with CNMs and quality improvement facilitator demonstrated that ad hoc audits are also conducted to inform implementation of continuous improvement projects (eg, discharge of acute medical patients; care planning for short stay patients). Residents' feedback is captured through annual residents' surveys, complaints/compliments, and collective or individual feedback received at resident and family meetings. There was documented evidence that residents' feedback had been discussed for quality improvement, for example improvements on facility communication with resident and family/whānau had been initiated as a result of feedback received.</p> <p>Quality data was observed to be compiled in automated or manual reports and collated for discussion and evaluation at board meetings, management team meetings, health and safety meetings, special clinical committees, RN meetings, and household meetings. Review of meeting minutes and attendance indicated that service providers/stakeholders had reviewed quality aspects relevant to their operations and level of management/governance during scheduled meetings.</p> <p>Quality outcomes and new identified risks are communicated to all staff through meetings, and those who are not in attendance sign to confirm that they have read the minutes made available to them (sighted). Feedback from risk and quality developments is shared with residents and family/whānau through meetings and communication as required.</p> <p>Quality and risk management performance progress is included in monthly reporting from the GM to the board. Quality system/service performance oversight and overall objectives are discussed at the annual</p>
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		<p>general meeting and during the development of quality/business plans every two years. This was explained by the GM interviewed.</p> <p>Residents' survey conducted since the last audit indicated high level of residents' satisfaction with the service. Discussion with staff and managers and document review confirmed that corrective actions from individual feedback had also been implemented.</p> <p>Corrective actions are developed, implemented and recorded from scheduled audits. However, corrective actions from meetings were not consistently documented.</p> <p>Health and safety policies and procedures, and a quality and risk management programme, provide a framework to manage risks to residents, staff, and visitors. Staff receive health and safety training as part of their orientation and education. A current hazard register was sighted, as well as reports that identify new identified hazards. Risks are rated and actions to mitigate risks are undertaken and documented.</p> <p>Review of meeting minutes verified that health and safety meetings are held four times a year, where health and safety issues are discussed with the CNMs and four representatives from different service categories. Hazards and risks are reported and evaluated by management to guide risk mitigation and inform quality and risk improvements.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The GM and CNMs interviewed regarding essential notification processes, described situations that should be notified under section 31 of the Health and Disability Services (Safety) Act 2001 and to relevant statutory authorities, would they occur. Those included but were not limited to: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. At the time of the audit, a change of board member was notified to the Ministry of Health under section 31. There had been no other essential notification required to the Ministry of Health or the DHB since the last audit.</p> <p>Staff interviewed confirmed awareness of the organisational policies and processes regarding the reporting and management of adverse events affecting residents, staff, the physical environment, and the organisation systems.</p> <p>There is an implemented electronic incident/accident reporting system in place that is up to date. Observed reports include a description of the event; corrective actions; follow-up of implementation; and sign off. Records demonstrated that staff notify the resident and the CNM of clinical incidents, and when necessary the whānau/EPOA and the GP. Required assessments were conducted in response to clinical events, and the residents' care plans were accordingly updated. There was documented evidence that observations, including neurological observations, had been undertaken as per policy and best practice guidelines following unwitnessed falls and falls with suspected head injuries.</p> <p>Information gathered from incidents/accidents inform quality improvement processes and are regularly shared</p>

		at health and safety meetings, management, RN and staff meetings.
<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>	PA Low	<p>Recruitment of new staff follows a process that adheres to principles of good employment practice and the Employment Relations Act 2000. Staff files reviewed across categories of personnel evidenced that the recruitment process involves but is not limited to: verification of identity and professional experience; police vetting; and an employment contract signed by all concerned. In the sample reviewed, there was evidence of a job description enclosed with the employment contract for all employees at initial recruitment. Documentation showed staff appraisals occur at least yearly. However, not all employees who had changed position had a current job description that outlined their new role.</p> <p>Practicing certificates were current for all health professionals who required them. The employee who drives the van has a current driving licence. Facility contract with the local licenced pharmacy was verified. Four out of thirteen nurses are interRAI certified assessors, which was confirmed by certification documents. All care givers except one held medication competencies.</p> <p>Staff files contain induction/orientation checklists with relevant core competencies. Continuous professional development takes place through sighted education calendars which include annual core competencies and role specific competencies that are relevant to the service provision for both long-term residents and acute medical patients. Clinical nurse managers interviewed discussed additional clinical education implemented to support acute clinical cares, for instance oxygen management, venepuncture and advance resuscitation. Regular reviews and additions to the education programmes support practice changes, upskilling of staff, and demands from residents' cares and situations. All education sessions are advertised at the nursing station, through meetings and individual communication, and staff interviewed reported they are supported to attend.</p> <p>There is a manual system to record education attendance. The system identifies the attendance achievement for each session, and the education received by each individual. Education session attendance records evidenced that ongoing education is undertaken by clinical staff to meet at least eight hours of required training per year. Staff interviewed confirmed they receive core competency training and opportunities for further education that meet the requirements of the service delivery.</p> <p>Education is delivered by the CNMs, by external providers, or through online learning. Care givers are encouraged to enrol with an industry training organisation to achieve level qualifications. Two-thirds of care givers employed by the facility have attained qualification level three or four. Nurses were supported in their undertaking of post-graduate studies, including a nurse practitioner training programme.</p>
Standard 1.2.8: Service Provider Availability	FA	A documented annual leave and rostering policy states organisation commitment to plan duty rosters and on-call staff to meet the standard and contractual requirements for the provision of care 24 hours a day, 7 days a

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>week. At interview, the CNMs explained how the number of available staff/staffing hours and skill mixes are planned and rostered to comply with policy.</p> <p>Review of sampled rosters evidenced that they are implemented as planned 24/7. There is at least one RN on duty on each shift, and support from a second RN in the morning when possible. Four care givers are on duty in the morning and are supported by an extra staff member for three hours to assist with personal cares. Two care givers are available in the afternoon, with the support of an extra care giver for three hours during busy early evening hours. The night team consists of one RN and one care giver or enrolled nurse. Permanent or casual care staff are called in to cover absences. There is a pool of 10 RNs, 3 ENs, and 23 care givers available. There was no uncovered absence for the staff on full duties in the rosters reviewed.</p> <p>Care teams, and pre-allocation of residents and medical inpatients to staff, are planned by the CNMs interviewed for each day. This helps balance the workloads and skill mixes required across the two wings of the facility, and to align clinical resources with resident/patient acuity needs. The nursing station where all staff are based is located at the junction of the two wings.</p> <p>The two facility CNMs take turns to support staff Monday to Friday. Each CNM works three days a week, with an overlap on Wednesday. The CNMs can be called in for assistance after-hours and during the weekend. Medical cover is ensured by a GP five days a week for daytime duties and after-hours on-call. Primary response in medical emergency nurses provide acute medical assistance during the weekend,. Ambulance services and Dunedin hospital emergency services are available for medical assistance and/or consultation. A camera has been installed in the facility emergency room to facilitate virtual consults with Dunedin hospital emergency care and medical specialists.</p> <p>A podiatrist, physiotherapist, and occupational therapist are available through routine community visits. Referrals to multidisciplinary teams can be made through the DHB.</p> <p>Non-clinical staff include domestic services, kitchen staff, administrative support, maintenance and gardening personnel.</p> <p>At interview, long-term residents, medical inpatients and family reported adequacy of staff levels and skills to complete the required cares and services in a timely manner.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded,</p>	<p>FA</p>	<p>Residents' records and medication charts are maintained through a new electronic system, with historical notes and records archived in physical files available at the nursing station. Residents' progress notes reviewed are completed every shift, detailing response to service provision and progress towards identified goals. The electronic system allows identification of staff making the entry. Review of electronic records evidenced that all current and relevant information is completed or logged into the system. InterRAI assessments are completed as required. Observations demonstrated that resident information can be</p>

<p>current, confidential, and accessible when required.</p>		<p>retrieved in a timely manner.</p> <p>Policies and procedures on resident information privacy and confidentiality are consistent with the requirements of the Privacy Act and Health Information Privacy Code. At interview staff described the procedures for maintaining confidentiality of residents' records. No personal or private resident information was on public display during the audit. Electronic data is password protected and can only be accessed by designated staff.</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>	<p>FA</p>	<p>Entry and assessment processes for residential care and acute medical services are developed, implemented and recorded.</p> <p>The rest home and hospital residents sign an admission agreement that provides information about the services provided under the DHB contract. An information pamphlet is also provided to residents and family outlining the residential care services. The patients admitted for acute medical services are provided with a pamphlet containing information about the medical inpatient service.</p> <p>The acute medical patients, long-term residents and their family confirmed in interviews the admission process was completed by staff in a timely manner and all relevant admission information was provided.</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>There are documented protocols and procedures related to transfers to and from the hospital. Transfer policies are current. Transfers may be arranged for urgent purposes. Staff confirm their understanding of the process to transfer patients which may include ambulance or other forms of emergency transport. Staff report a cohesive and collaborative relationship with key staff in secondary and tertiary health services which support efficient timely transfers. The medical patients' discharge plans ensure the required support is available at the time of the patients' discharges. Discharge planning occurs from admission for medical patients and includes actions to meet a successful discharge. The medical patients interviewed confirmed they are informed and involved in discussions through the ward rounds.</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</p>	<p>FA</p>	<p>The organisation has a current medication policy and procedure to guide staff in all aspects of medication management. The medication management system is implemented to ensure that residents and patients receive medicines in a safe and timely manner.</p> <p>Medications are stored in a secure temperature-controlled environment. Swipe card access to the medication room is required with access for selected staff only. The controlled medication is stored appropriately to meet legislative requirements.</p>

<p>practice guidelines.</p>		<p>Records of temperatures for the medicine fridge have readings documenting temperatures within the recommended range. Medication administration observed at audit complied with safe administration practices.</p> <p>An annual medication competency is completed for all staff administering medication as confirmed by staff and management interviews and staff files. Staff interviewed they have adequate trolleys and resources to manage the entire facility including the acute medical patients. The controlled drug register is current and correct. Weekly and six-monthly stocktakes are conducted. Expired or unwanted medication is returned to the pharmacy weekly. The service uses pharmacy pre-packed medication for residential care residents, and these are checked by the RNs on delivery to the facility. New stock is delivered weekly or as required from a local pharmacy or from Dunedin.</p> <p>The organisation utilises an electronic medication system to manage medications. Staff have been trained and have completed competencies to use the new system. Review and observation of the use of the new system, confirms a safe and appropriate system is in place.</p> <p>There were no residents/patients self-administering medication at the time of the audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided by an external provider. The food is cooked off site, arrives chilled or frozen and is reheated as required. The menu is developed and then reviewed by a dietitian. The seasonal menu has a four-week rotation. There is a documented, current food control plan. The most recent audit occurring in March 2021.</p> <p>A nutritional assessment is completed for each patient/resident on admission. Their personal food preferences, special diets and modified nutritional requirements are communicated to the external food service company via an electronic system. The process is overseen by the CNMs. Kitchen staff prepare meals daily and provide options should residents/patients' needs change. Fresh fruit is available. During interview, the kitchen staff confirmed the processes of food delivery, storage, food preparation and serving of food. Patient, resident and family interviews confirmed satisfaction with the food services.</p> <p>Staff records confirmed staff have undergone suitable food handling training. This included one CNM. Ongoing food safety training is provided by the external provider. The kitchen and food storage areas were observed as clean with appropriately stored food. All decanted food in fridges at the time of the audit was appropriately labelled, dated and stored. A meal service was observed during the audit. The food provided was attractively served and residents interviewed provided positive feedback.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>Assessments for the residential care residents are completed by needs assessment staff for rest home or hospital level of care. Residential care residents are declined entry if the needs assessment does not reflect the services provided at the facility. The outcome of the assessment is communicated to the assessed person and all other concerned parties.</p> <p>The medical patients are assessed following GP referral. During interview, the GP confirmed that arrangements are made to transfer patients to the appropriate service if the need for additional services is identified. Patients and referrers confirmed they are informed of decisions when the patient has been referred/transferred following an assessment. The GP consults with tertiary hospital medical staff regarding the patient's referral to the service or direct referral to another service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>All medical patients' and residential care residents' records reviewed were legible. Members of the multidisciplinary team record entries in the patient/resident files. The recently implemented electronic patient management system, supports staff to maintain records on each shift. All documentation reviewed was current and comprehensive. Care plans reviewed evidenced that staff have completed entries on the care plan to guide individualised care and treatment. Care plans are integrated and promote continuity of service delivery. A staff signing sheet is maintained to ensure all staff providing care have read and understood the care plan. Patients and family interviewed confirmed staff keep them informed about progress and ongoing residents' care needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	FA	<p>Allied health staff are available to provide services to residents and patients. Documentation confirms allied health involvement as required. Interviews with clinical staff and management confirmed there is access to allied health services. Nursing assessments and nursing care plans are completed on standardised templates/assessment tools. The medical plans of care and interventions are documented in patients'/residents' medical notes and/or progress notes. Patient and resident interviews confirmed satisfaction with the care and treatment received. Staff reported a working knowledge of the assessments</p>



desired outcomes.		required for each resident and those to utilise should a change in condition occur.
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is a documented activities programme which is implemented for the rest home and the hospital residents. The activities programme is developed by the acting activities coordinator and reviewed by a RN. Medical patients can engage as they feel comfortable. Residents and family interviewed confirmed the programme is implemented from Monday to Friday each week and provided by weekend staff. The programme covers: physical; social; recreational; emotional; spiritual and cultural needs of the residents. During interview, the activities coordinator confirmed the collaborative nature of the programme delivery alongside clinical staff who often support elements of the programme. A general programme is developed and implemented as well as personalised activities plans for each resident. One on one time is provided for residents who desire individual support. Outings into the community occur weekly or more often in the organisations van. Residents with mobility challenges are supported. Group outings for like- minded residents occur with visits to rural areas and the hairdresser. Residents were observed participating in activities on audit days. The residents and family interviewed reported a high level of satisfaction with the variety of activities provided. Residents' voluntary attendance and participation in activities are recorded.</p> <p>A physiotherapist conducts physiotherapy assessment and mobility plan for both the acute medical patients and residents in the hospital and rest home when then is required. Clinical staff confirmed during interview that assessments and mobility plans are conducted following a referral from the GP or RNs and documented in the resident' and patients' files.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Documentation reviews and interviews undertaken with staff confirmed medical patients' plans of care and treatments are evaluated on an ongoing basis to monitor progress. Files reviewed have evidence of evaluation occurring by those health professionals involved in the individual patient's care. Electronic progress notes record evaluation is ongoing. The GP conducts ward rounds in the inpatient medical unit each day. The frequency of evaluation and reassessment of acute medical patients is based on acuity and progress of the patient.</p> <p>Residents care plans record individualised goals and the required interventions. Residents' care plan evaluations occur six-monthly or sooner if their condition changes. Where progress is not as expected, there is timely assessment and changes made to the patient's care and treatment. Short-term care plans are used for short-term problems. These are evaluated depending on the risk level of the acute care problem.</p>
<p><b>Standard 1.3.9: Referral To Other Health And Disability</b></p>	FA	<p>Referrals to other services, specialists and/or clinics are facilitated when required and documented appropriately. A copy of the referral information is retained in the patient's or resident's individual record.</p>

<p>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>		<p>There was evidence in patient's files reviewed of the use of the inter-hospital transfer form with all required patient information completed. Referral to community services were documented in the same way and included in the resident/patient file. Where resident and patient referrals had been made in files reviewed, comprehensive referral documentation was recorded.</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>	<p>FA</p>	<p>Implemented policies and procedures for the safe management of chemicals, infectious substances and waste. Ensure protection of staff, visitors and residents from environmental hazards and comply with legislated requirements.</p> <p>Observations and procedures described by staff for the disposal of categories of waste and infectious substances aligned with policies.</p> <p>Supply and decanting of chemicals is contracted to an external provider with data sheets and posters available in locked storage areas. Interviews with relevant staff evidenced that they had received orientation to the chemical management system. Sighted spill kit was labelled and available to staff. Interviews and training documentation evidenced mandatory education is provided to all staff on risk and hazard identification, and chemical handling.</p> <p>Protective clothing and equipment supply was observed in relevant areas. Staff were observed to be suitably equipped during duties that involved a risk of cross-contamination.</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>PA Low</p>	<p>Maniototo has moved its operations to a new building in April 2019. A certificate of public use valid until 20 May 2021 was displayed in the entrance to the building. Reviewed documentation evidenced that all remaining building works have been completed, and application for a code compliance certificate was imminent. Monthly fire and emergency checks that comply with legislation are conducted as part of the compliance requirements for the building and plants (sighted).</p> <p>A maintenance person is employed three days a week to ensure the residential environment remains fit for purpose. The GM provides support and leave cover for the maintenance person and addresses emergency requests on the days when the latest is not on site. Review of documentation established that maintenance requests from staff and residents are reviewed daily, prioritised, actioned, and signed off. Detailed corrective actions are documented.</p> <p>External contractors perform test and tagging of electrical equipment and checking and/or calibration of</p>

		<p>biomedical devices and equipment, that were observed to be up to date for the equipment in use. This includes checking and testing of electrically operated beds. The facility outing van showed evidence of a current warrant of fitness and a current registration. A reviewed asset register is used to support and record the annual maintenance of equipment by external contractors.</p> <p>The CNMs interviewed explained that internal audits are conducted to verify the status of bed mattresses, and the mattresses which are not fit for purpose are decommissioned.</p> <p>Internal processes for the preventative maintenance of buildings, grounds, and mechanical equipment were documented and reviewed. The processes reviewed and discussed at the time of the audit covered all aspects of maintenance required for the physical environment to remain safe. However, not all processes had been implemented.</p> <p>External gardens, pathways, decks and patios are accessible for residents with mobility aids and provide seating and shade. External ramps are equipped with handrails. Concrete pathways and ramps were observed to be sealed and maintained. The maintenance person is responsible for the maintenance of the lawns, while a gardener is employed for the maintenance of the gardens. All were observed to be kept in good order.</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>There are adequate numbers of accessible showers, hand basins and toilets located throughout the facility to attend to personal hygiene. All rooms have their own ensuite, except three double rooms which have a shared ensuite. An acute emergency room can be used as a double room for acute medical patients if required, and shared inpatient toilets and bathrooms are available in its proximity. A large communal bathroom is available for all residents' use that includes a bath equipped with a ceiling hoist.</p> <p>On observation, there is plentiful space in the toilet/shower/bathing facilities for the manoeuvre of mobility equipment and to accommodate care givers. Handrails and accessible call bells are present in all areas for safety. Privacy of shared facilities is ensured through locking and vacant sign systems.</p> <p>Observations and interviews with residents, family and staff confirmed that shower/toilet facilities have sufficient equipment to support personal cares, for example hoisting devices, shower stools and raised toilet seats.</p> <p>Separate toilets for staff and visitors are available near the main entrance.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided</p>	<p>FA</p>	<p>All long-term residents' bedrooms except two provide single accommodation. Three rooms are available to share, of which one was occupied by two residents of the same gender who were not related but agreed to sharing of space. This was confirmed through consent documentation and interviews.</p>

<p>with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>An emergency room is available for acute after-hours community assessments. Managers interviewed explained that this room could be used for two acute medical inpatients if required. The room is equipped with one bed, and a second bed would be sourced and brought in if necessary.</p> <p>Separating curtains are available in all shared rooms to ensure privacy during private cares and interventions.</p> <p>Residents and observations confirmed that they are encouraged to personalise spaces with own decor and to bring in furnishings that add to private comfort and expression of personality. On observation, all rooms have large spaces suitable for residents with physical disability needs, and to support mobility, assistance, and the free manoeuvre of equipment.</p> <p>Rooms are organised to include a seating area for residents and/or visitors. Observations and staff interviews verified that individual furniture provided by the facility, such as beds and seats, are recently purchased or in good condition. Hospital grade chairs and beds were observed to be provided to residents who require them. Interviews with residents and family confirmed their satisfaction with the personal spaces and equipment supplied.</p> <p>All wheelchairs and care equipment are stored in dedicated areas which are readily accessible. Electric scooters are powered and parked in a garage.</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>Maniototo has a number of communal areas that were observed while touring the facility during the on-site audit, and met the recreation needs of the residents. One large communal lounge is open space and opens to a large patio with new outdoor lounge furniture allowing residents and visitors to congregate outside. Seating within the lounge is re-arranged daily to allow residents to engage in social activities, entertainment, and relaxation, in large or small groups. The lounge has a piano and other diversional equipment, a big screen, and a fridge available to store residents' own food (refer to 1.4.2.4).</p> <p>A small lounge equipped with a computer desk and comfortable seating can be closed off for quiet activities or private gatherings. Two small lounges/whānau rooms are accessible at each end of the facility, provide indoor seating, and connect the external grounds. One of this room is closed proximity of the palliative care room and holds a fridge where residents/patients can store their own food.</p> <p>One communal dining area offer a table service to residents and promotes independence. Dining furniture is appropriate to the needs of the residents and is reminiscent of a home setting.</p> <p>Effective use of communal spaces was described by the residents and family interviewed. There are large grounds available for walks.</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>Cleaning and laundry processes are monitored as part of six-monthly audits. Review of residents' surveys indicated high level of satisfaction with laundry and cleaning services.</p> <p>An external contractor provides chemicals to the facility and is responsible for monitoring formula effectiveness. The chemicals were observed to be labelled and stored securely. A cleaner interviewed explained implementation of documented cleaning schedules made of daily routine tasks and 'spring clean' duties. A team of two cleaners covers morning duties, five days a week. The facility was observed to be clean and tidy.</p> <p>There was one sluice room available for the disposal of bodily waste and substances and washing of care equipment, which was observed to respect separation of dirty and clean items handled and stored.</p> <p>Care givers share responsibility for the facility laundry. Linen, personal laundry, and infectious items are sorted in different coloured bags. Laundry of linen/sluice items is performed by a contractor off-site. Care givers interviewed explained the process for the collection and delivery of dirty and clean linen by the contractor, which met the requirements for the hygienic transportation of laundry. Residents' personal laundry was observed to be managed by care givers on-site, including washing, drying, sorting, and distribution. The laundry area has one door but delineated zones to avoid cross-contamination of soiled and clean laundry items.</p> <p>Residents and family interviewed expressed no concerns about the laundry process.</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>Records sighted confirmed that all staff complete fire emergency and safety training as part of their orientation and annual education. A sprinkler system was observed throughout the buildings as well as emergency exit signs. Plans on display indicated fire cells and emergency exits for evacuation. Registered nurses on duty act as fire wardens and emergency first responders. Registered nurses are posted at the nursing station which is central to the facility. Valid first aid certificates were identified for all clinical staff and non-clinical staff who require them.</p> <p>The New Zealand Fire Service approved the fire evacuation plan in March 2019 and there have been no building structural alterations since the approval. Documented evacuation drills were reviewed that are conducted six-monthly.</p> <p>A documented emergency management plan sets procedures in response to disasters, civil defence emergencies, and infection outbreaks/pandemics. The plan includes procedures for the evacuation of all residents, including specific procedures for residents with mobility challenges or oxygen cylinders for example.</p> <p>Stores of civil defence emergency supplies were sighted to be adequate for the facility size and complexity. A diesel powered generator and fuel reserve provide enough energy resources for up to three days. Water</p>

		<p>tanks with pressure system would supply the required amount of fresh water in an emergency. Torches and a barbeque are also available. Emergency food is stocked and rotated as required. Stocks of continence products, care supplies, and personal protective equipment, are adequate to cater for the needs of residents in an emergency.</p> <p>A wireless call bells system is in place that includes a self-check system and a power backup system in case of disruption. Call bells are available to summon assistance in all residents' areas. Call bells are diverted to pagers carried by clinical staff and displayed on a central screen at the nursing station with the call location. Call bells are locked and can only be cancelled by the responding clinical staff onsite, with their personal key. The call bell system is checked weekly by the maintenance person to ensure safe functioning.</p> <p>The facility has a helipad available for urgent transfer of patients to Dunedin hospital.</p> <p>Surveillance cameras are in place in key communal areas and entrance ways to support the security of residents, staff and visitors. Signage notifies the public of the presence of closed-circuit television (CCTV). After hours doors and windows are locked at different times in summer and winter. A door bell ringing system allows to request entry after hours. Visitors are required to sign in.</p> <p>Fire brigade and the police are called to assist with breaches of safety or security.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>On observation, all rooms and communal living areas receive natural light. Windows can open from inside to let fresh air in, including sky windows in the corridor ceilings. The facility buildings are heated by radiators which are not burning to touch, and heat pumps throughout. Heat pump provide air conditioning if required.</p> <p>Residents' and family' interviews confirmed that the facility environment was spacious, well lit, well ventilated and comfortable. Residents' surveys' reports demonstrated high satisfaction with the environment temperature.</p> <p>The facility has a smoke free policy that applies to the buildings and the grounds. Staff interviewed reported that at the time of audit, there was no resident who smoked or vaped. Written information for residents indicates that private areas for smoking/fumes, away from public areas, can be organised through management if needed.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	<p>FA</p>	<p>The infection prevention and control programme and the role of the infection control team is identified and documented. The two CNMs lead the infection prevention and control team and coordinate the programme across the organisation and report to the GM. The infection control programme including the infection control plan is reviewed annually. The CNM interviewed confirmed their input into the management of infection control at the facility including the COVID-19 response.</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>The delegation of infection control matters is documented in policies and job descriptions. There is evidence of regular meetings and reports on infection control matters. These are regularly communicated to staff and management, through handovers, meetings and in the staff information folder. Staff, patients and residents suffering from infectious disease are prevented from exposing others while infectious. Senior staff interviewed confirmed they have adequate access to recourses on-site or through external providers to manage any infectious outbreaks.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection prevention policies, procedures and programme meet the needs of the organisation and provide information and resources to inform and guide staff.</p> <p>The infection prevention and control representatives are qualified health professionals (RNs) with relevant skills and knowledge. The infection prevention and control staff have access to residents/patients records and diagnostic results, as required. Regular reports on infection related issues are recorded by regular monitoring systems. Implementation of the infection prevention and control programme is monitored via internal audits.</p> <p>Patients discharged from a tertiary hospital will have infection prevention and control screening completed prior to discharge. Documentation of their infective status is provided prior to admission. The clinical staff screen all new admissions for any potentially infectious illnesses that may lead to transmission. The requirement for isolation is identified on each patient's/resident's admission and continued in the ward. Staff interviewed could describe the precautions that are required and the process for managing any required response. Staff have received infection prevention and control education. Staff were observed wearing protective clothing where required.</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</p>	<p>FA</p>	<p>There are current policies, procedures and guidelines to support infection prevention and control systems. The policies and procedures reflect current accepted good practice, safety and legislative requirements. The policies are appropriate to the size and nature of the organisation.</p> <p>Staff interviewed confirmed they had access to policies. Policies are reviewed regularly with input from staff and linked to other documentation in the facility.</p>

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>The infection prevention and control education is provided to new staff at orientation. A blend of online and face to face education is available. An infection prevention and control questionnaire and online infection prevention and control training is completed by staff. Completion of the training/education is recorded in each staff members' personnel file. Specific training for COVID-19 related infection has been completed by an external consultant. Participation in questionnaires and online training in infection control is evidenced in staff records.</p> <p>The infection prevention and control representatives are resource persons for patients, residents, family and other health professionals. This was confirmed during staff interviews. Senior staff confirmed during interview that infection prevention and control representatives have completed COVID-19 and general education relating to infection control.</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>During interviews the CNMs confirmed the surveillance of infections is completed in both the acute medical and the residential care services at the facility. The surveillance data sighted evidenced surveillance is recorded for the medical ward, long-term hospital care, and the rest home.</p> <p>The infection prevention and control representatives are responsible for gathering, monitoring, collating and analysing the surveillance information. Results are reported to both staff and management at staff meetings or sooner if required. Concerns are reported at handovers and to management in a timely manner. Trends and recommendations are communicated to clinical staff. Minutes of meetings are maintained.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy is documented and implemented. The definitions of restraint and enablers are consistent with this standard. Records sampled confirmed that staff actively work to minimise the use of restraint. The role of the restraint coordinator is shared between the two CNM. Practices related to restraint were reviewed and observed during the audit period.</p> <p>There were four residents assessed as requiring restraint and no residents/patients requesting the use of enablers on audit days. All documentation reviewed related to the use of restraints was complete, with episodes of restraint appropriately evaluated. Interviews with the GP, staff and management confirmed awareness of restraint and enabler use and a focus on minimisation of restraint use. Staff reported restraint was used as a last resort. The use of enablers is voluntary.</p>



<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The organisation has developed a restraint approval process policy which is documented and implemented.</p> <p>The use of restraint is approved by the GP, clinical team and the family. The approval process requires an assessment of risk and evidence that other methods of management have been trialled. Staff interviewed discussed a collaborative ongoing evaluation process related to restraint use and the risks involved in using restraint. There was documented evidence that consideration of residents changing needs/condition was considered where restraint was utilised. The required approvals were sighted in restraint records sampled. The restraint register was completed.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint risk assessment tool is completed for each identified restraint used. The restraint assessment process is fully documented and includes the requirements of this standard. Resident records sampled confirmed completed assessments and approvals. The most common reason for implementing a restraint in the records samples was for safety reasons.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The approved restraints are used as a last resort. Discussions with staff confirmed alternatives were trialled prior to restraint use and evidence of this practice was sighted in records sampled and through discussion with staff and residents. When in use, restraints are monitored for safety. Staff complete monitoring documentation and were observed monitoring residents in restraint. There have been no reported incidents related to unsafe restraint use. Restraints were observed to be in safe use during the audit. The restraint care plans record the risks associated with restraint use and a plan of care is recorded.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint use is evaluated during the care plan review process. Alternatives to restraint use are considered and the use of restraint may be discontinued. The resident's safety is ensured through monitoring and this is recorded and discussed by staff to identify any ongoing risks and/or safety issues. Residents' records evidenced ongoing evaluation related to the use of restraints. Staff interviews confirmed restraint evaluation occurred.</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>Both CNMs lead the restraint practise for the organisation. Compliance with the restraint policy and procedure is monitored by management. Staff interviews, and review of documentation/files confirmed staff are trained in de-escalation techniques and restraint minimisation practises. Quality review of restraint practices is conducted.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective action plans from internal audits, were recorded electronically, included in a register, and showed documentation of implementation and follow up or close out. Managed incidents, accidents and complaints had documented evidence of corrective actions that were completed and signed off.</p> <p>However, corrective action plans from meetings were not consistently documented. Review of sampled minutes from staff, RN, household, management, and health and safety meetings evidenced that when a corrective action was discussed, and required to be completed: (i) the person responsible for the action was not always registered; (ii) the action implementation was not always documented/evaluated; (iii) the evidence of sign off or follow up by the person responsible was not always recorded.</p> <p>A corrective actions' register has been developed by the facility during audit to record all corrective actions issued through meetings. The documented register has space to record a corrective action plan, their date of issuing, the person responsible, the date of completion/sign off, and an evaluation</p>	Corrective action plans from meetings are not consistently documented.	<p>Ensure corrective action plans from meetings are consistently documented, implemented and evaluated.</p> <p>90 days</p>

		<p>of the action effectiveness/outcome.</p> <p>However, the new process is yet to be fully implemented.</p>		
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>Documented job descriptions outlined the skills and knowledge required for each position of employment. The CNMs had sighted job descriptions which included their roles as infection prevention and control and restraint coordinators.</p> <p>A new activities coordinator has stepped into their role in November last year, to replace the diversional therapist on long-term leave. The new activities person previously worked as a care giver/kitchen aid in the facility and had experience as a teacher aid in the past. Interviews established that the acting activities coordinator was well supported in their new role by the CNMs, and that they were cognisant of the requirements for their position and for the delivery of cares to residents.</p> <p>The acting activities coordinator had signed a new employment contract.</p> <p>However, there was no evidence of a documented job description attached to the contract that outlined the skills and accountabilities of the activities coordinator, and met the requirements of the aged residential care agreement. The GM interviewed confirmed that no job description had been provided to the employee.</p>	<p>The acting activities coordinator had no job description for their role.</p>	<p>Ensure the acting activities coordinator receives a job description that outlines their responsibilities and skills for this role.</p> <p>60 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	<p>Environmental inspections are regularly conducted and documented by the maintenance person that allow identification of hazards, development of corrective actions, and completion (sign off). Hot water temperatures are monitored and documented weekly. At interview, the maintenance person discussed the interventions they would initiate, should the hot water temperatures depart from the required safety range. The temperature of the medication room is monitored to promote the safety of stored medicine.</p> <p>There was a new process in place to monitor the temperature of fridges used by residents/patients to store their own food in the palliative care room and two communal areas. However, the process was yet to be implemented.</p>	<p>i) Documented process to monitor the temperatures of the fridges available for residents/patients own use, is not yet implemented.</p> <p>ii) The documented schedule for</p>	<p>Ensure the preventative maintenance schedule is fully implemented and documented.</p> <p>90 days</p>

		<p>Standing mobile trolleys are serviced annually by an external contractor (documentation reviewed). Wheelchairs were listed to be regularly checked by the maintenance person; however, completion of checks was not documented.</p> <p>At the time of audit, the van used for outing was equipped with a new first aid kit and fire extinguisher to replace missing equipment. However, there was no schedule implemented to verify that the van safety equipment is present at all time and is in good order. There was a plan articulated by the GM to check the van hoist on a regular basis, however this was still to be implemented.</p>	<p>preventative maintenance of the wheelchairs is not implemented.</p> <p>iii) The van safety equipment, and the van hoist, need regular checks.</p>	
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## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.