

Te Aroha and District Health Services Charitable Trust - Te Aroha & District Community Hospital

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Te Aroha and District Health Services Charitable Trust
Premises audited:	Te Aroha & District Community Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 April 2021 End date: 23 April 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	34



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Te Aroha and District Community Hospital is governed by a community trust board. The service provides rest home and hospital level care (geriatric and medical) for up to 45 residents. The service also has five general practitioner beds. On the day of the audit there were 34 residents. The residents, relatives and general practitioner interviewed commented positively on the care and services provided at Te Aroha.

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

The clinical/facility manager has been in her role five years. She is supported by a second in charge/registered nurse, enrolled nurse operations administrator and long-serving staff.

There were no areas identified for improvement at this certification audit. The service continues to embed quality systems and upgrade/refurbish the facility.

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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Care at Te Aroha is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural needs are met. There are linkages to the marae and kaumātua for Māori residents. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

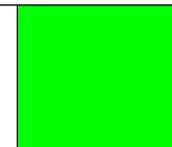
Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The quality and risk management programme includes service philosophy, goals and a quality/business plan. Meetings are held to discuss quality and risk management processes. Residents'/family meetings are held regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. Falls prevention strategies are in place that includes the analysis of falls incidents. An education and training programme has been implemented with a current training plan in place for 2021. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Registered nursing cover is provided on all shifts in the hospital building at all times.

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.

There is an admission pack available on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are evaluated at least six monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

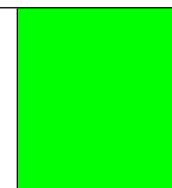
Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

The building holds a current warrant of fitness. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. There is a trained first aider on duty 24 hours.

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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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. There were no residents with restraint and two residents with an enabler. All appropriate documentation was in place. Staff receive training in restraint minimisation and challenging behaviour management.

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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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with nine care staff (four healthcare assistants, one registered nurse- RN (second in charge), one clinical facility manager (CFM), one enrolled nurse (EN) and two activity coordinators confirmed their familiarity with the Code. Interviews with nine residents (six rest home and three hospital) and three families (two rest home and one hospital) confirmed that services being provided are in line with the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in six resident files; two rest home (including one respite care), and four hospital (including one younger person -YPD and one resident funded by ACC). Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Healthcare assistants (HCAs) and registered nurses (RNs) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative's lives. Six resident files sampled have signed admission agreements.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy as part of the set training programme. Information about accessing advocacy services information is available in the entrance to both buildings. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. All residents and relatives interviewed confirmed that relative/family visiting could occur at any time. Residents are supported to attend community events such as school functions and shopping trips.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a documented complaints policy and complaint forms are available near the entrance of both buildings. Information about complaints process and a form is provided in the admission package. Interview with residents and relatives demonstrated an understanding of the complaints process. One complaint from the Health and Disability Commission in October 2019 had been fully investigated, resolved to the satisfaction of the complainant and closed off in January 2020. There are no further complaints for 2020 and 2021 to date. A complaint register is in place. The template letter for acknowledgment of complaints and follow-up includes agencies involved and the right to advocacy with contact details.</p> <p>Care staff interviewed were able to describe the process around reporting complaints. Family members and residents interviewed stated they were aware of the complaints process should they have a concern.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display throughout the facility and on the community noticeboard. There are leaflets available in the foyer of both facility buildings. The service can provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the information pack is discussed with the resident and the family/whānau. The information pack includes a copy of the Code.</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>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting residents' privacy and could describe how they manage maintaining privacy and respect of personal property. There are privacy locks in communal showers and toilets. There is a policy that describes spiritual care. All residents interviewed indicated that their privacy and dignity was respected. Staff receive training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There are three Māori residents who identified as Māori at the time of the audit. The clinical facility manager identifies as Māori and acts as an advocate for Māori residents with access and links to local marae, iwi and kaumātua. School groups regularly perform kapa haka. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process as demonstrated in the three resident files reviewed. Discussions with staff confirmed that they are aware of the need to respond to cultural differences and acknowledged the importance and participation of whānau in the delivery of care.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment, including resident's cultural, spiritual beliefs and values, is used to develop a care plan. There is evidence of resident (if appropriate) and/or their family/whānau consultation in the plan of cultural care. Staff receive training on cultural safety/awareness. Church services are held on site and residents are supported to attend churches of their denomination in the community. The service holds an annual "all souls day" in remembrance of residents who have passed away.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has a staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. Staff read and sign the House rules on employment. Two volunteer agreements cover confidentiality and code of rights clause. The orientation provided to staff on induction</p>

		includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service is a member of an aged care association and receive regular updates on current practice in aged residential care. There are policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had an understanding of principles of aged care and stated that they feel supported by the management team. External speakers are invited to provide education and training. The RNs have access to te koatea on-line education. Registered nurses each have an individual portfolio and complete relevant training and internal audits related to their portfolio such as fall, documentation, wounds, pharmacy/medications, weight management, tube management (e.g., peg feeds), infection control, health and safety and restraint minimisation. There is a focus group who are representative of clinical and support services staff and meet monthly to review quality improvements, internal audits and quality data.</p> <p>The service has used community donations to continually upgrade the environment including a palliative care room with space and furnishings for family/whānau and purchase of a bariatric wheelchair.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incident/accidents forms reviewed for the month of February 2021 had documented evidence of family notification.</p> <p>Relatives interviewed, confirmed that they are notified of any changes in their family member's health status. There are two-monthly resident meetings which are open to families. Meeting minutes are displayed on the noticeboard. Any issues raised from these meetings are followed up by the clinical/facility manager. Interpreter services are available as required. Residents interviewed confirmed that communication between them and the care staff and management was good. There are regular newsletters that keep family/whānau updated on facility matters. A Facebook page links family to service updates and activities (with consent gained from residents).</p>
Standard 1.2.1: Governance The governing body of the	FA	A community trust board of nine people governs Te Aroha and District Community Hospital. Board members have experience in finance, accounting, property and human resources and legal aspects. The service provides rest home and hospital level care (geriatric and medical) for up to 45 residents. On the

<p>organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>day of audit there was a total of 34 residents. In the 16-bed rest home building (includes one double room) there were 13 rest home residents and two hospital level residents with a MOH letter of dispensation. In the hospital building of 29 beds (including 5 general practitioner beds) there were 16 hospital residents (including one ACC funded resident and one younger person), one respite rest home resident and two long-term rest home residents. There were no residents in the GP beds. There were no residents under medical services, palliative care contract, or rest and recuperation contract on the day of audit.</p> <p>There is a 2018 – 2021 business, quality and risk management plan in place. This plan includes the core values - Respect, Compassion, Communication and Cooperation. Strategic goals and objectives are documented and are reviewed at the monthly Trust Board meetings. The clinical/facility manager attends the Board meetings and provides clinical governance.</p> <p>The clinical/facility manager (RN) has been in the role four and a half years. She is supported by an RN/second in charge appointed August 2020. They both work Monday to Friday and share the on-call. They also complete morning RN duties as required. An enrolled nurse/operations administrator coordinates the internal audit programme and training programme.</p> <p>The clinical/facility manager has undertaken a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months including attending an aged care study day on Aspiring Leaders. She has also completed a six-week understanding dementia on-line course.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the temporary absence of the clinical/facility manager, the RN/second in charge takes on the role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk</p>	<p>FA</p>	<p>There is a quality plan and risk plan with identified goals for Te Aroha including falls prevention, pain management, clinical documentation and continue to review policies and procedures. Interviews with staff confirmed that there is discussion about quality data, including accident/incidents, infections, internal audit outcomes, concerns/compliments at the monthly focus meeting and at other facility meetings including staff and RN meetings. Meeting minutes are available for staff who are required to read and sign the minutes. The clinical/facility manager is responsible for providing oversight of the quality programme on</p>

<p>management system that reflects continuous quality improvement principles.</p>		<p>site. She is supported by an operations administrator (EN) who coordinates internal audits and the education programme.</p> <p>The service has contracted an aged care consultant to assist with policies, provide aged care updates/information and benchmarking. The clinical/facility manager has been reviewing policies and adapting these to the service. Staff are made aware of any new/reviewed policies and paper-based manuals are available.</p> <p>The internal audit programme for 2020 has been completed and the 2021 programme is underway. Internal audits are allocated to the relevant person and cover environmental, support services, clinical and documentation audits. Re-audits and corrective action plans are completed for audit results less than expected.</p> <p>The June 2020 resident/relative survey was not completed due to Covid-19 and is planned for June 2021. All residents admitted to GP beds complete surveys on the month of admission. The results are collated, and the clinical/facility manager responds to any concerns.</p> <p>The service has a health and safety management system that is regularly reviewed. The health and safety committee meet monthly and includes the management team, representatives from each area and two board members. A health and safety representative has attended external training and the maintenance person is registered to attend. There is a current hazard register for each area of work.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical/facility manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff/RN and focus meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents who sustain an incident/accident. Ten incident/accident forms for February 2021 were reviewed and demonstrated that appropriate clinical follow-up and investigation has occurred following incidents. Neurological observations were completed for unwitnessed falls and for residents with an obvious injury to the head.</p> <p>Discussions with the clinical/facility manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. The public health and MOH were notified of a meningococcal outbreak in July 2020.</p>
<p>Standard 1.2.7: Human</p>	<p>FA</p>	<p>There are human resource management policies in place. This includes that the recruitment and staff</p>

<p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>selection process requires that relevant checks are completed to validate the individual's qualifications and experience. Eight staff files were reviewed (two RNs, one enrolled nurse, four healthcare assistants and one cook) and identified that all relevant documentation was completed before employment was offered. Completed orientations and job descriptions were on file and staff interviewed could describe the orientation programme provided. Current annual staff appraisals were in all staff files reviewed. A copy of practising certificates for qualified nurses and allied health professionals is maintained.</p> <p>The in-service education programme for 2020 was disrupted due to Covid-19 restrictions and recommenced again in June 2020. The 2021 education plan is underway. The operations administrator/EN coordinates the speakers, workbooks and competencies to be completed. There are two in-service sessions offered on each topic to allow for all staff to attend. The physiotherapist provides training on safe manual handling. Registered nurses' complete clinical competencies including medications, male catheterisation, dialysis, PIC lines, intravenous therapy and venepuncture procedures. All competencies are signed off by an approved trainer. Registered nurse has access to te koatea on-line training and DHB study days. There are seven RNs with six interRAI trained. Registered nurses are allocated administration days on the roster to complete interRAI assessments.</p> <p>Discussions with the healthcare assistants and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There are policies in place to determine staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The clinical/facility manager (RN) is on duty Monday to Friday and is available on call weekends and after hours. The clinical operations administrator is on duty Monday to Friday. There is a RN on duty 24-hours a day. The RN on duty oversees the rest home. The RN/second in charge works Monday to Friday. This allows for the RN on duty to complete RN duties in the rest home each weekday morning.</p> <p>The healthcare assistant (HCA) rosters are as follows;</p> <p>For the rest home – Lawrence House (separate building) with 16 beds including one double room. There were 13 rest home residents and two hospital level residents (one had been re-assessed for rest home care). On the morning shift there is one HCA on the full shift and one HCA from 7-10.30 am. On the afternoon shift there is one HCA on the full shift and one HCA from 4.45 pm-7.30 pm. There is one HCA at night.</p> <p>For the hospital wing of 29 beds (includes five GP beds) there were 16 hospital level residents and three rest home residents. There are four HCAs on the morning shift with two on the full shift and two who finish at 1.30 pm. On the afternoon shift there are four HCAs who work the full shift and two who finish at 8 pm.</p>

		<p>There is one HCA on nights. HCAs in the hospital are available to assist in the rest home if required.</p> <p>Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RN and clinical/facility manager, who responds quickly to after-hour calls.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregiver or RN.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The clinical facility manager and second in charge/RN (2IC) screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The six admission agreements reviewed meet contractual requirements and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they received the information pack and received sufficient information prior to and on entry to the service. Family members reported that the clinical facility manager or 2IC RN are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and</p>

		admission in to the facility.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-medicating on the day of audit, however policy and procedures outlining assessment, review and safe storage are in place should the service require it. There are standing orders in use which are documented, including indications for use, frequency and maximum doses. These are reviewed three-monthly by the GP. There are no vaccines stored on site.</p> <p>The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses administer medications, have up to date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperatures are checked daily. Eye drops viewed in the medication trolley had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twelve medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</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>	FA	<p>The lead cook oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring February 2022. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu is approved by an external dietitian.</p> <p>All resident/families interviewed were very complimentary about the meals provided. Additional snacks are available at all times.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</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>Files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed. Initial interRAI assessments and reviews are evident for five of six resident files. The respite care resident was not required to have an interRAI assessment.</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments are appropriately completed according to need. For the resident files reviewed, the outcomes from interRAI assessments and risk assessments are reflected into care plans.</p>
<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>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the dietitian, wound care specialist and PEG nurse specialist. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the service and care provided.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p>

		<p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included; three chronic wounds, one skin tear, two post-surgical, two lacerations and one hospital resident with a grade 1 pressure injury (facility acquired).</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds. All monitoring requirements including neurological observations had been documented as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are three activity coordinators who plan and lead all activities, covering seven days per week for rest home and hospital, and Monday to Friday for day care clients. Residents were observed participating in planned activities in all three areas during the time of audit, including group exercise in the main lounge, with the activities team adapting exercises to the various abilities of the clients to facilitate a fun and inclusive session.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, pet therapy, floor games and bingo.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage are offered. Residents in the main facility also have the choice to attend alternate activities with younger clients attending day care should they prefer.</p> <p>There are at least weekly outings including supported shopping trips on the facility's own wheelchair accessible minibus. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated. There are visiting community groups such as various church denominations and children's groups.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were very positive about the activity programme.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Five of six resident care plans reviewed (excluding the resident on respite) had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. Care plan evaluations were documented and reviewed progress to meeting goals. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The clinical facility manager interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the clinical/facility manager and registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	FA	<p>The building holds a current building systems status report (expiring February 2022) issued in lieu of a building warrant of fitness as one or more systems could not be signed off during Covid lockdown. There is a planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged, expiring April 2023. The hoist and scales are checked annually and are next due to be checked April 2022. Hot water temperatures have been monitored in</p>

<p>facilities that are fit for their purpose.</p>		<p>resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas and decked areas are well maintained. All external areas have attractive features, including extensive landscaped grounds, and raised vegetable beds which are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</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 five resident rooms with ensuite in the rest home and three in the hospital. There are also sufficient communal toilets and showers. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of ensuites and communal toilet/shower/bathing facilities and they have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</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>There are large and small communal areas. Activities occur in all areas of the facility, with residents being assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The dining areas are spacious, inviting and appropriate for the needs of the residents.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry of linen is outsourced. There is a separate 'dirty' area for linen awaiting collection and a 'clean' area for deliveries. Personals are done on site and there is a defined clean and dirty flow within the laundry area. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. Sluice rooms were kept locked when not in use.</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>	FA	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. There is a civil defence cupboard with additional supplies in an external locked shed. There is sufficient water (bottled) and food. The installation of water tanks is at the planning stage at Board level. All civil defence supplies are checked regularly. There is a gas barbeque available for alternative cooking. An on-site generator is automatically connected in the event of loss of power. The generator is checked monthly by a contractor.</p> <p>There is an approved fire evacuation scheme in place. The six-monthly fire drill during lockdown was delayed, however there was an actual fire alarm prompting a full evacuation in December 2020. Fire safety inspections are carried out monthly. There is a trained first aider on duty 24 hours.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mat when activated light up on corridor lights that are visible from all areas in the facility. There are planned call bell checks. Security policies and procedures are documented and implemented by staff. The buildings are secure at night with after-hours doorbell access, which is connected to the call bell system. There is security lighting.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control</p>	FA	<p>The infection control programme, its content and detail, is appropriate for the size, complexity and degree</p>

<p>management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>of risk associated with the service. The infection control coordinator/RN has been in the role since 2015 and has a job description that outlines the responsibility of the role. Monthly infection control reports are provided to the focus meeting and meeting minutes are made available to staff. The infection control programme is reviewed monthly, and a report provided by the clinical/facility manager to the Trust Board meeting.</p> <p>There is QR screening at the door and visitor/contractor declaration forms to be completed on entry to the facility. There are adequate hand sanitisers appropriately placed throughout the facility. Visitors are asked not to visit if unwell. Influenza vaccinations are offered to all residents. Residents and relatives interviewed confirmed they were kept informed regarding Covid-19 restrictions.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator (IC) has completed Ministry of Health on-line training April 2020 and attended an infection control study day at the DHB November 2020. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The clinical/facility manager, IC nurse and RN team have external support from the IC team at the DHB who assisted with personal protective equipment required during lockdown. Infection control updates and newsletters are received from the contracted aged care consultant.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Infection control policies and procedures have been developed by the service, referenced and have been reviewed April 2021. The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles and responsibilities. There is a Covid-19 resource manual including alert levels fact sheet.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. All new staff complete orientation which includes infection control. All staff complete an infection control workbook annually and handwashing competencies. In addition, there has been training on the correct use of donning and doffing of personal protective equipment.</p> <p>Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records.</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>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The IC collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed at the focus meeting and other facility meetings. The aged care consultant provides benchmarking and an annual comparison of infections. Meeting minutes including graphs are available to staff. Trends are identified, analysed and preventative measures put in place. Internal audits have been conducted.</p> <p>Systems in place, are appropriate to the size and complexity of the facility.</p> <p>There was a meningococcal outbreak (cluster) in July 2020. Two residents were admitted to hospital with sepsis and were diagnosed with meningitis. The service received advice and support from the Medical Officer of Health who also notified the MOH (email sighted). Staff were offered a meningitis vaccine and medication.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents with restraints and two residents who had voluntarily requested the use of an enabler (bed-wickets). All appropriate documentation was in place and the enabler use is evaluated when the care plan evaluation is due. Staff education on restraint minimisation and de-escalation (June 2020) and management of challenging behaviour (February 2020) has been provided.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.