Wyndham and Districts Community Rest Home Incorporated - Wyndham and District Community Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Wyndham and Districts Community Rest Home Incorporated
Premises audited:	Wyndham and Districts Community Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 June 2021 End date: 9 June 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: 20	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

The Wyndham District and Community Rest Home provides rest home level care for up to 23 residents. There were 20 residents residing at the facility on audit days.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the district health board. The audit process included the review of policies and procedures, review of resident and staff files, and observation and interviews with residents, family members, management, staff, physiotherapist, board member, and a general practitioner.

The residents and family members spoke positively about the care provided.

There were two areas identified as requiring improvement relating to: good practice and medication management. The organisation has been allocated two areas where they have effectively exceeded the minimal requirements of this standard. The organisation demonstrates a commitment to continually improving the quality of services and remains firmly integrated within their local community.

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.	 	Some standards applicable to this service partially attained and of low risk.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process, and the Nationwide Health and Disability Advocacy Service is accessible. This information is brought to the attention of residents and their families on admission to the facility. Residents and family members confirmed their rights are being met.; staff are respectful of their needs and communication is appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent is practised, and written consent is gained when required. Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.	 	Standards applicable to this service fully attained.

The Wyndham and Districts Community Rest Home incorporation is the governing body and responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned. There are systems in place for monitoring the service provided, including regular monthly board meetings.

The facility is managed by an experienced and qualified nurse manager who is a registered nurse with aged care experience, and who has been in this position since 2015. The nurse manager is responsible for the clinical and day to day operations in the facility.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented on accident/incident forms. Facility meetings are held where there is reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

There are policies and procedures on human resource management. A mandatory education programme is provided for staff.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice,

Resident records are maintained in a confidential, accurate and timely manner. The privacy of resident information is maintained. The name and designation of staff making entries in clinical files is recorded and legible.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after the resident's admission to the facility.

The interRAI assessment is used to identify residents' needs and these are completed within the required timeframes. The general practitioner completes a medical assessment on the resident's admission and reviews occur thereafter on a regular basis.

Long term care plans are developed and implemented within the required timeframes, they are individualised and based on an integrated range of clinical information. Residents' needs, goals and outcomes are identified. All residents' files reviewed demonstrated evaluations were completed six-monthly or when the resident's condition changes. Residents and their relatives are involved in the care planning process.

Short term care plans are in place to manage short term issues or problems as they arise. Handovers between shifts guide continuity of care and teamwork is encouraged.

An electronic medication management system is in place. Medications are administered by the registered nurse and care givers who have completed current medication competency requirements.

The activity programme is managed by an activities co-ordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The service uses its facility van for outings in the community.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control plan. Kitchen staff have food safety qualifications.

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.
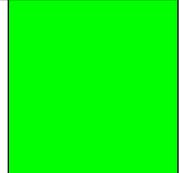
The building has a current building system status report displayed. There is a reactive and preventative maintenance programme, and this includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Residents' bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids, and to allow for care to be provided. Lounges, dining areas, and sitting alcoves are available for residents and their visitors. External areas and gardens are safe for residents to mobilise around.

A call bell system is available to allow residents to access help when needed. Security systems are in place with regular fire drills completed.

Protective equipment and clothing is provided and used by staff. Chemicals are safely stored. The laundry and cleaning service is completed by staff and monitored.

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.

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse. On the day of the on-site audit there were no restraints or enablers in use. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.	 	Standards applicable to this service fully attained.
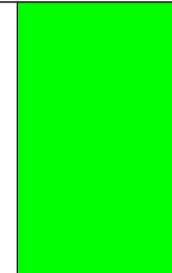
The infection control programme is appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed, and trended. Monthly surveillance data is reported to staff. There have been no outbreaks since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	1	1	0	0
Criteria	2	89	0	1	1	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	Policies, procedures and processes are in place to meet the obligations in relation to the Code of Health and Disability Services Consumers Rights (the Code). Staff interviewed understood the requirements of the Code. Staff were respectful of residents' rights as observed in their communications with residents and family members; encouraging residents' independence; and maintaining residents' dignity and privacy. Training on the code is included in the staff orientation process and part of the ongoing training.
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	The informed consent policy guides staff in relation to informed consent and staff interviewed understood the principles and practice of informed consent. The residents' files evidenced documented consents using the organisation's standard consent form that includes consent for photographs, outings, and collection and sharing of health information. Consent is also obtained on as-required basis, such as for covid-19 and influenza vaccinations. There was evidence of advanced directives signed by the residents. Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with their relative and

		consulted when treatment changes were being considered.
		Staff were observed gaining verbal consent for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. Staff demonstrated understanding of the advocacy service., Information available in brochure format at the entrance to the facility. Residents and family members confirmed their awareness of the service and how to access this.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to maintain their community interests and networks, and to visit their families. The activities programme includes regular outings in the facilities mobility van. The service welcomes visitors and has unrestricted vising hours. Family members advised they feel welcome when they visit. The organisation's close links with the community is a strength of the service and was evident throughout the audit. The WRH is supported by local community members, the rural community, and local schools (refer continuous improvement rating in criteria 1.2.3.8 additional quality projects).
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Policies and procedures relating to complaints management are compliant with right 10 of the Code. Systems are in place that ensure residents, and their family are advised on admission to the facility of the complaint process and the Code. The complaints forms are displayed and accessible within the facility. Staff interviews confirmed their awareness of the complaints processes. Residents and families demonstrated an understanding and awareness of these processes. The NM is responsible for complaints management. A complaints register is maintained. The register noted four verbal complaints for 2020 all closed and two for 2021. One relates to a resident missing money (refer continuous improvement rating in criteria 1.2.3.8) which is closed, the other relates to a human resource matter which is currently being managed by an external lawyer on behalf of the trust. There are no complaints currently with any external agencies.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	During the admission process, new residents and their families are given information on the Nationwide Health and Disability Advocacy Service. Posters on the Code are displayed in English and Te Reo Māori at the facility. Residents and family members interviewed were familiar with the Code and the advocacy service posters and brochures. Residents and family stated they would feel comfortable raising issues with staff and management.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff communicated their knowledge about the need to maintain residents' privacy and were observed doing so throughout the audit. Residents are encouraged to maintain their independence by participating in community activities and outings, confirmed at resident and family interviews. (Refer 1.1.12.2 for continuous improvement example). Residents' records sampled confirmed that residents' cultural, religious, social needs, values, and beliefs were identified, documented, and incorporated into their care plan. The policy on abuse and neglect was understood by staff interviewed, including what to do should there be any signs. Education on abuse and neglect is part of the staff orientation programme. The residents and their families confirmed they receive services in a manner that has regard for their dignity, privacy, spirituality, and choices.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has a Māori Health Plan that guides staff in meeting the needs of the residents who identify as Māori. Any additional cultural support, if required would be accessed locally, confirmed at staff interviews. At the time of the audit there were no residents who identified as Māori. The in-service education programme includes cultural safety. Staff interviewed demonstrated an understanding of meeting the needs of a resident who identified as Māori and the importance of whanau.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect	FA	The individual preferences, values and beliefs of residents are documented in the care plans reviewed. Residents and family members stated they had been consulted about residents' individual ethnic, cultural, spiritual values, and beliefs, and confirmed that these were respected.

their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members stated that residents were free from any type of discrimination or exploitation. Staff are guided by policies and procedures and communicated understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. Staff orientation includes information relating to all forms of discrimination and exploitation, professional boundaries and expected behaviours.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	PA Low	The Wyndham and Districts Community Rest Home incorporated (WRH) policies and procedures are based on current legislation and relevant guidelines. The annual education programme includes sessions that promote a high level of service delivery. The service has access and support from external allied health professionals for example: specialist nurses, physiotherapist, and wound care specialists. There is a policy for falls risk management. However, the falls management policy regarding neurological observations does not reflect best practice. Neurological observations are not recorded for all unwitnessed falls and are recorded for 48 hours post fall only.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	A review of incident/accident forms showed timely communication with residents and or family members. Communication with family members is also recorded in the residents' clinical files. The residents and family members stated they were kept informed about any changes to their own or their relative's status and were advised about incidents or accidents and the outcomes of medical reviews. Staff interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Residents and family members are informed of residents' meetings and the meeting minutes reviewed evidenced relevant information is shared. Interpreter services can be accessed via the district health board (DHB) or Interpreting New Zealand when required. This information is also provided to residents/families as part of the admission process.

| Standard 1.2.1: Governance

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Wyndham and Districts Community Rest Home Incorporated is the governing body for Wyndham and Districts Community Rest Home (WRH). There are eight board members, with a variety of skills and expertise including management, constructive human resources and a clinical background. One community member has been approached as to expressions of interest. The board provides governance and the strategic direction of the WRH. The chairperson of the board was interviewed and confirmed the strategic direction and business plan of Wyndham and Districts Community Rest Home Incorporated. This included increased occupancy, community involvement and the six documented specific goals of the organisation. Board meetings reviewed confirmed achievement towards the strategic goals is monitored through the monthly meetings and management reports completed by the nurse manager (NM).

The Business, Quality, Risk and Management Plan makes reference to a strategic and business plan. A quality statement, mission statement, philosophy, goals, and objectives are documented and have been reviewed by the board.

The NM is responsible for the operational and clinical management of the service and has been in this role since 2015. The NM is a registered nurse with a current practising certificate and has experience in the management of residential care facilities.

The NM is responsible for the oversight of clinical services and is supported in the role by another RN two days per week.

The facility can provide care for up to 23 residents, with 20 beds occupied at the audit. This included 20 residents requiring rest home level care.

There were no residents requiring hospital level care, under the age of 65 years of age, boarders, or on respite care at the time of the audit. |
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| Standard 1.2.2: Service Management

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. | FA | The nurse manager is supported by the administrator and the registered nurse, both of whom can perform components of the manager's role during a temporary absence. Delegations are documented. |
| Standard 1.2.3: Quality And Risk Management Systems | FA | Wyndham and Districts Community Rest Home incorporated has a documented quality management system. The system was purchased by an external provider with the organisation |

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		individualising policies and procedures, to ensure they reflect the scope and complexity of services provided. The service policies are subject to reviews and reference legislative requirements (refer 1.1.8.1). Policies are available to all staff and maintained in hard copy. There is a system for reviewing and updating related documents with evidence of ongoing reviews in records of meeting minutes sampled.
		Service delivery is monitored through complaints, review of incidents and accidents, key performance indicators, patient satisfaction survey, and implementation of an internal audit programme. The review of the quality management data evidenced the schedule was consistently followed. Improvement opportunities are identified and evaluated for effectiveness. All quality data is combined and discussed at staff, quality, and board meetings.
		Facility meetings are conducted, and minutes evidenced communication with staff around aspects of quality improvement and risk management. Staff report that they are kept informed of quality improvements.
		The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed, and risks minimised or isolated.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff understood the adverse event reporting process and were able to describe the importance of reporting near misses. Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident/incident forms are completed by staff who either witnessed an adverse event or were the first to respond. Incident/accident forms are reviewed by the NM and signed off when completed. The RN's undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents (refer 1.1.8.1).
		Policy and procedures comply with essential notification reporting: for example, health and safety, human resources, and infection control. The NM is aware of situations which the service would need to report and notify statutory authorities including police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks; and changes in key clinical managers. Authorities have been notified, this includes notification to the Ministry of Health and the police following the theft of the residents' valuables (refer 1.2.3.8 example of continuous improvement project).

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Written policies and procedures in relation to human resource management are available. Current copies of annual practising certificates were reviewed for all staff and contractors that required them to practice. The selection and approval of new staff is the responsibility of the NM. The skills and knowledge required for each position are documented in job descriptions which outline accountability, responsibilities, and authority. These were reviewed on staff files along with employment agreements, reference checks, and police vetting. Interviews with caregivers confirmed new caregivers are paired with a senior care giver for shifts or until they demonstrate competency on a number of tasks including personal cares for residents. Caregivers confirmed their roles in supporting and buddying new staff. Completed orientations were present in all staff files reviewed. Competency assessment questionnaires for relevant competencies required for specific positions, such as hoists, handwashing, medication management, moving and handling, restraint, blood sugars, pump usage were sighted in staff files reviewed. The NM and the enrolled nurse (EN) are interRAI competent. The organisation has a mandatory education and training day. Staff performance is monitored with an annual appraisal schedule in place and current staff appraisals were sighted in staff files sampled.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Staffing levels meet contractual requirements. The NM, the RN and three on call RNs provide on-call service during the week and to cover and the weekends. Adequate on-site RN cover is provided 5 days a week by the NM and the RN. Registered nurses are supported by sufficient numbers of care givers. There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Rosters are completed using a predetermined template by the administrator and overseen by the NM. Rosters sighted reflected that staffing levels meet the resident acuity and bed occupancy. Each shift has a senior caregiver who has a current first aid certificate and medication competency. Caregivers also complete laundry tasks, with additional support staff rostered for kitchen and laundry duties. Residents and families reported staff provide them with adequate care. Care staff reported there were adequate staff available and that they are able to get through their work.

Standard 1.2.9: Consumer Information Management Systems	FA	There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of residents' records. Files, relevant resident care, and support information could be accessed in a timely manner. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.
Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		Residents' files are maintained securely. Electronic data is password protected and can only be accessed by designated staff. Archived material is also kept securely and easily retrievable.
		All components of the residents' records reviewed include the residents' unique identifier. The clinical records reviewed are integrated, including information such as medical notes, assessment information, and reports from other health professionals. Entries are legible, dated and signed by the caregiver, RN, or other health professional, and include their designation. Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals.
Standard 1.3.1: Entry To Services	FA	Needs Assessment and Service Coordination (NASC) assessments are completed for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. There is a comprehensive information pack provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service processes are implemented, ensuring compliance with entry criteria.
Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		Residents and family members interviewed stated they were satisfied with the admission process and that it had been completed in a timely manner. Information about Wyndham Home had been made available to them. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	FA	Transition, exit, discharge or transfer is managed in a planned and coordinated manner.
Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		Interviews with RNs and review of residents' files confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers. The facility maintains a folder with individual transfer forms, copies of resuscitation status and current medication charts for emergency transfers. There is evidence that the rest home ensures a safe transfer to acute services and accompanies the

		resident in the event a family member is not available. All relevant information accompanies residents when a patient is moved to another service or facility. Follow-up occurs to check that the resident is settled.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	A current medication management policy identifies all aspects of medicine management in line with the relevant legislation and guidelines. A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices are in line with legislation, protocols and guidelines. The required three-monthly reviews by the GP were recorded electronically. However, resident allergies and sensitivities were not consistently documented on the electronic medication chart. The service uses pharmacy pre-packaged medicines that are checked by an RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing orders used at the facility. Review of the medication fridge evidenced that the service does not store or hold vaccines and interview with the RN confirmed this. The medication refrigerator temperatures and medication room temperatures are monitored according to policy. Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks and six monthly stocktakes of medications are conducted in line with policy and legislation. The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management however recording of the effectiveness of PRN medication following administration was inconsistent. Current medication competencies were evident in staff files. There were four residents self-administering medication during the on-site audit. A process is in place to ensure ongoing competency of the residents and self-administration of medication is authorised by the GP. Safe and appropriate storage for medications was provided. However, there is inconsistent documentation of the amount, frequency and effectiveness of self-administered medication.

| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared on site and served in the dining rooms or in the resident rooms if requested. The seasonal menu has been reviewed by a dietitian, with the summer menu implemented at the time of audit. The food control plan expires in March 2022.

The senior cook was on leave at the time of audit. Food management training and certificates for the senior cook were sighted. The kitchen staff have completed relevant food hygiene training from the dietician. All staff working in the kitchen have had infection control training.

Food temperatures are monitored appropriately and recorded. The kitchen was observed to be clean, and the cleaning schedules were sighted.

A dietary assessment is undertaken for each resident on admission by the nurse manager or RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident's dietary needs change. Diets are modified as needed, staff working in the kitchen confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning.

Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. Residents and families interviewed stated that they were satisfied with the meals provided.

All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cooks are responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated. |
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| Standard 1.3.2: Declining Referral/Entry To Services

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service has a process in place if access is declined. When residents are declined access to the service, residents, and their family / whānau, the referring agency and general practitioner (GP) are informed of the decline to entry. The resident would be declined entry if care requirements are not within the scope of the service or if a bed is not available. A waiting list is maintained. |
| Standard 1.3.4: Assessment

Consumers' needs, support requirements, and preferences are | FA | The initial nursing assessments which include dietary, pressure injury risk, falls risk and continence and the initial care plan are completed within 24 hours of admission. The initial care plan guides care for the first three weeks. RNs or the EN complete the interRAI assessment within the required |

gathered and recorded in a timely manner.		timeframes. The long-term care plan is based on the interRAI assessment outcomes. Assessments are recorded, reflecting data from a range of sources, including: the resident; family/whānau; the GP/NP and specialists.

The staff use an early warning assessment tool to identify any changes in the resident's condition, with this used to develop any short-term interventions required. If the issue becomes longer term, a reassessment occurs, and the long-term care plan is amended to reflect the resident's current needs.

Policies and protocols are in place to ensure continuity of service delivery. The interRAI and assessment tools are reviewed at least six-monthly, including pressure injury and falls.

Interviews with residents and families confirmed their involvement in the assessments, care planning, review, treatment, and evaluation of care. |
| Standard 1.3.5: Planning

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Long term care plans are developed with resident and family/whānau involvement. All residents' files sampled had an individualised long-term care plan. Long term care plans describe interventions in sufficient details to meet residents' assessed needs. Short-term care plans are developed for the management of acute problems.

Review of resident files showed service integration with clinical records, activities notes, and medical and allied health professionals' reports and letters. Interviews with residents confirmed that they have input into their care planning and review, and that the care provided meets their needs. |
| Standard 1.3.6: Service Delivery/Interventions

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Long term care plans are completed by the RN and based on assessed needs, desired outcomes, and goals of residents. Care planning includes specific interventions for long-term and acute problems. Interventions are reviewed within required timeframes and updated if there are changes in the health status of a resident.

The GP documentation and records reviewed were current. The GP interviewed confirmed that they were notified of problems in a timely manner, medical orders were followed, and that care was of a high standard. After hours medical care is provided.

There was evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Where wounds require additional specialist input, this is initiated.

Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Family |

		communication is recorded in the residents' files. The nursing progress notes are recorded and maintained.
		Monthly observations such as weight and blood pressure were completed and are up to date.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The residents' activities programme is implemented by the activities coordinator. Activities for the residents are provided five days a week, from 9.30am to 2.30pm. The programme is displayed on the residents' noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural and community events. Regular van outings into the community are arranged. Church services are held weekly. The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the RN. Information on residents' interests, family and previous occupations is gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed every six months at the same time the care plans are reviewed and are part of the formal six-monthly multidisciplinary review process. The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging in and enjoying a variety of activities. Refer 1.1.12.2 example of continuous improvement project.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Long term care plans are evaluated every six months in conjunction with the interRAI re-assessments or as the residents needs change. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. Short term care plans are evaluated and either signed off or information transferred to the long-term care plan as appropriate. Residents and family interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident's records and documented in the individual resident files reviewed.
Standard 1.3.9: Referral To Other Health And Disability Services	FA	The service facilitates access to other medical and non-medical services. Where needed, referrals are sent to ensure other health services, including specialist care, are provided for the resident.

(Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		Referral forms and documentation are maintained on resident files. Referrals are regularly followed up. Communication records reviewed in the residents' files, confirmed family/whānau are kept informed of the referral process.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies and procedures in place for the management of waste and hazardous substances. Personal protective equipment is available throughout the facility. Domestic waste disposal meets council requirements and is removed from site as required. Infection control policies include the use of single use items. Chemicals and used products are securely stored or disposed of. All staff receive training on the use of personal protective equipment (PPE) and the management of waste and hazardous substances. Hazardous substances are included in the hazard identification process and there is an emergency event action card for waste and hazardous substances incidents.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building system status report is displayed. There is a preventative and reactive maintenance programme in place. Staff are aware of the process of reactive maintenance to ensure timely repairs are conducted, confirmed at staff and board members interviews. Maintenance is completed by external contractors when requested in a timely manner. Visual observation evidenced the facility and equipment are maintained to an adequate standard, documentation reviewed, and staff interviews confirmed this. The testing and tagging of equipment and calibration of biomedical equipment is current. The external areas are safely maintained and are appropriate to the resident group and setting. Residents are protected from risks associated with being outside. The gardens are maintained by the garden "fairies" local community support workers, and provide enjoyment for residents, staff, and visitors. Staff interviews confirmed they have appropriate equipment to meet residents' needs. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs. The facility has two vans that are used for residents' outings and these meet legislative requirements.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There is a combination of shared bathrooms and private ensuites. All rooms have a handbasin. The fixtures fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All shared and communal toilets and showers have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence. Separate toilets are available for staff and visitors.

Hot water temperatures are monitored monthly. When there have been hot water temperatures above the recommended safe temperature, action is taken, and rechecking of the temperature occurs to ensure it is maintained at a safe temperature. |
| Standard 1.4.4: Personal Space/Bed Areas

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Residents' bedrooms are personalised to varying degrees. The bedrooms are single occupancy rooms. There is one bedroom that can be used to occupy a married couple, this has not been used to date.

Bedrooms are large enough to allow staff and equipment to move around safely and to provide space for residents. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is adequate access to lounges, dining areas and sitting areas/alcoves. Residents were observed moving freely within these areas. Residents confirmed there are alternative areas available to them if communal activities are being run in one of these areas and they do not wish to participate in them. |
| Standard 1.4.6: Cleaning And Laundry Services

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry policies and procedures are available. Laundry is completed on site by the caregivers. The laundry has good separation of clean and dirty areas. The caregiver interviewed, described the management of laundry including the transportation, sorting, laundering, and the return of clean laundry to the residents.

Cleaning is completed by designated cleaners. The cleaner described the cleaning process and the use of chemicals for cleaning purposes. There are safe and secure storage areas for cleaning equipment and chemicals and staff have access to these areas as required. Sluice rooms are |

		available for the disposal of soiled water and waste. Handwashing facilities are available throughout the facility with alcohol gels in various locations.
		Safety data sheets are available. Effectiveness of the cleaning and laundry programme is monitored through internal audits, residents, and family feedback.
		The facility was observed to be clean on the days of the audit.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Documented systems are in place for essential emergency and security services. The fire evacuation scheme for the facility has been approved by the New Zealand Fire Services. The trial fire evacuations are conducted six monthly. The last fire evacuation was conducted April 2021. The staff training register evidences all staff have completed first aid training, fire evacuation education and the fire drill. There is emergency lightening, gas for cooking, emergency water supply, blankets available in case of emergency. There is a generator which will supply lighting in the event of a power cut. Heating is supplied by two local boilers. Emergency preparedness audits are conduct with the emergency preparedness policies and procedures being recently reviewed and upgraded following the evacuation of the facility in 2020. Refer 1.2.3.8 example of continuous improvement following evacuation of residents February 2020. The call bell system in place is used by the residents', and/or staff to summon assistance if required and is appropriate to the resident groups and settings. Call bells are accessible/within reach and are available in resident areas. Staff interviews confirmed security systems are in place and staff are aware of security processes.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light and safe ventilation. All rooms have at least one good sized window for natural light. Two diesel boilers are the heat source for the water radiator heating system throughout the facility ensuring the internal environment is maintained at a comfortable temperature. Residents and families confirmed the facility is maintained at a safe and comfortable temperature.
Standard 3.1: Infection control management	FA	Wyndham Home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. The infection control

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.		programme is appropriate for the size and complexity of the service which is reviewed annually. The nurse manger is the infection control nurse (ICN) and has access to external specialist advice from the DHB infection prevention and control (IPC) nurse practitioner (NP). A signed job description for the ICN, including role and responsibilities, is in place. Staff are made aware of new infections through daily handovers on each shift, progress notes and clinical records. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICN is responsible for implementing the infection prevention and control programme. There are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facilities quality and staff meetings and reported to the board monthly. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention and control programme.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	Wyndham Home has documented policies and procedures in place that reflect current best practice relating to infection prevention and control. Policies include guidelines for the exclusion of any staff member or if there family member is unwell. Staff observed were complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICN has completed infection control training via the MOH online course, and they attend training at the DHB annually. All staff attend infection prevention and control training. Staff education on infection prevention and control is provided at orientation, at the annual training days and at staff meetings. Records of attendance are maintained. Staff interviewed confirmed that education on infection prevention and control is provided.

		Education with residents occurs on a one-to-one basis and at resident meetings. This includes reminders about hand washing, remaining in their room if they are unwell, increasing fluids during hot weather and Covid19. Hand sanitisers are provided in each room for residents to clean their hands before meals. Information regarding infection prevention and covid19 is displayed on the notice boards.
		Staff receive notifications and updates about infection control via meetings and at handovers.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The Wyndham Home surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. The NM is responsible for the surveillance programme. Internal audits are completed. Infection control surveillance occurs monthly with analysis of data and reporting at staff and quality meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infections. In interview staff reported they are made aware of infections through handovers; progress notes; short term care plans and verbal feedback from the NM and RN. New infections and any required management plan are part of the handover, to ensure early intervention occurs. Families are updated by phone, email or text if required. Short term care plans are developed to guide care and evaluate treatment for all residents who have an infection. There have been no outbreaks since the last audit. Covid-19 information is available to all visitors to the facility. Infection prevention and control resources were available should a resident infection or outbreak occur. The ICN has developed a comprehensive system to optimise efficient and effective response to any outbreaks that may occur. This includes efficient labelling, storage and accessibility for equipment and staff training.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The nurse manager is the restraint coordinator, they provide support and oversight for enabler and restraint management in the facility. The coordinator is conversant with restraint policies and procedures. On the day of the audit, no residents were using restraints or enablers. Restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of minimisation. Regular

		training occurs and review of restraint and enabler use is completed and discussed at all quality and staff meetings.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	PA Low	There is a falls management policy. However, the WRH falls policy states that neurological observations are not required for unwitnessed falls where the resident stated they have not hit their head. The policy states that neurological observations are required to be completed for 48 hours following the fall if the resident indicates that they have hit their head or if there is obvious injury. (Refer to 1.3.4)	The WRH falls risk policy does not follow best practice for recording neurological observations following an unwitnessed fall	Ensure that residents have neurological observations recorded for 72 hours following any unwitnessed fall. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and	PA Moderate	There is a medication management policy and staff who administer medications have current competency assessments. However, documentation of allergies and sensitivities, effectiveness of PRN medication and usage of	Documentation of medication management does not meet	Ensure documentation of all aspects of medication

appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		self-administered medication is inconsistent. a) In three out of twelve medication charts reviewed there was no documentation of allergies and sensitivity status. b) The effect of prn pain relief was documented on the pain chart and in the progress notes but not on medimap. There was no documentation of prn effectiveness on medimap or in the progress notes for any other prn medication administered such as eyedrops and laxatives. c) There was no documentation of the usage of PRN medications by four residents who self-administered medications.	legislative and best practice requirements for example: a) Documentation of allergies and sensitivities on the electronic system. b) Recording of the effectiveness following all PRN medication administration. c) Recording of the time, amount, and effectiveness of all self-administered medications.	management meets legislative and best practice requirements. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.	CI	The nurse manager (NM) reported during covid-19 lockdown it was noticed residents missed the involvement with their local community. Therefore, the organisation developed a project to ensure WRH extended their community involvement to ensure residents maintain their involvement with the local community and people of all ages and background. This includes: a) Gateway students, work experience at the facility. b) Duke of Edinburgh students, visiting and interacting with residents. c) Menzies College students, visiting and providing a musical experience. d) Riding for disabled, providing pony cart rides and miniature pony's visiting residents inside the facility. e) Local gymnasium raising money for Christmas gifts and presenting to the residents. f) Visiting another local rest home for the "wearable arts day", this included dressing the resident and their mobility walkers.	Projects regarding improving and maintaining community links resulted in a variety of ages and community activities for the residents.

		g) The local community "garden fairies" who maintain the gardens and encourage resident involvement to their individual ability. Residents reported they enjoyed the activities and loved seeing the variety of visitors coming to the facility. Photos of the activities are proudly displayed throughout the facility.	
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	CI	There is evidence of continual improvements made in quality areas and communication of the organisation. Refer criteria 1.1.12.2 for example of continuous improvement in communication. A quality improvement register is maintained. There have been five improvement projects since 2020. Theses cover a range of improvements environmental, security, resident activities, and staffing communication. The rationale and outcome for each improvement is documented. Quality improvement plans are developed for each project for situations which require additional input to achieve the desired outcome. Action plans include the area identified, the actions required, responsibilities, timeframes and evaluations of the actions taken it closed. a) A corrective action plan was developed following the February 2020 flood and the required evacuation of all residents. A debrief with all staff following the event highlighted areas of concern or where improvements in the evacuation process could be improved. For example: evacuation checklist for each resident to be completed prior to the resident leaving the facility. Resident grab bags that contain the resident's assessment information, (such as allergy status diabetic, falls risk) and continence products. A new phone messaging service. Findings and recommendations from the event have been presented to other the Southern regional facilities. b) Following a theft of a resident's valuables an investigation resulted in the installation of security cameras at all exit doors, public areas and staff working areas. Family, residents, and staff were notified prior to the installation. Notices in the facility advise any visitors that cameras are working in this area. A small personal safe with keypad access was bolted into the floor in each residents' wardrobe. Family and residents may have access at any time. c) It was noted that the residents did not attend all the activities available. In order to reflect who was present, sick or not interested a individual resident monthly planner of who attended was developed. The planner is then part of the interRAI assessment review process. The project has been implemented with planning documented for evaluation of the value of the planner planned in six months. d) The kitchen employees reported issues regarding communication and reporting with	The effectiveness of the corrective action process has resulted in increased opportunities for improvement of services, outcomes, and service delivery.

		management following issues with staffing, resources and daily menu planning. For example, residents' numerous requests for food that was not offered on the menu and at the time catered for. A new communication form has been developed and is utilised daily to report through to the NM and reported at staff meetings.	

End of the report.