

Oceania Care Company Limited - Wharerangi

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 The DAA Group 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: | Oceania Care Company Limited |
| Premises audited: | Wharerangi |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 29 September 2021 End date: 30 September 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: | 40 |

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

Wharerangi Rest Home and Village provides aged residential care for up to 47 people who require hospital, rest home or secure (dementia) level of care. The service is operated by Oceania Healthcare Limited.

Day to day management and all service delivery is overseen by a business and care manager (BCM). The BCM is supported by an RN clinical manager (CM) who manages the overall delivery of clinical care. Both the acting BCM and CM are suitably qualified and experienced as managers in aged care. They are directly supported by two Oceania executive leaders, a regional clinical manager and regional operations manager. The regional clinical manager was on site during this audit.

There have been no changes to the size or scope of the services provided since the previous surveillance audit in 2019. A request to the Ministry of Health (MoH) in 2020 to increase the number of dementia beds from 10 to 13, by reconfiguring three dual purpose beds was actioned, however, a subsequent application has been made to revert back to 10 dementia beds. There has been no demand for additional dementia beds in the area and accommodating extra residents in the dining and lounge areas was considered to be problematic.

This certification audit was conducted against the Health and Disability Services Standards and the service provider's contract with the district health board. The audit process included a desk top review of policies and procedures, and on site review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner (GP). Feedback from all interviewees was positive.

There were no areas identified as requiring improvement as a result of the audit. A rating of continuous improvement was allocated in the infection prevention and control standard.

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. |
|--|--|--|

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Wharerangi Rest Home and Village when they are admitted. Opportunities are provided to discuss the Code, consent, and availability of advocacy services at the time of admission and thereafter as required.

Services at Wharerangi Rest Home and Village are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for any residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required and bi-lingual staff.

Wharerangi has linkages to a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively. There have been no complaints investigated by external agencies since the previous audit.

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 annual business and quality risk management plans include the scope, direction, goals, values and mission statement of the organisation. Experienced and suitably qualified people manage the services being delivered.

The quality and risk management system includes monitoring service delivery and other operations through internal audits. Quality improvement data is collected, analysed for trends and leads to improvements. Staff are involved, and feedback is regularly sought from residents and families.

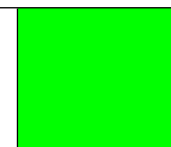
Adverse events are documented with corrective actions implemented where necessary. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery.

The appointment, orientation and management of staff is based on good employment practices. A systematic approach to identify and deliver ongoing training, supports safe service delivery and includes regular individual performance review.

Staffing levels and skill mix meet the changing needs of residents

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.

Resident admission to the facility is appropriate and efficiently managed with liaison evident between the Lakes Needs Assessment Service Co-ordinator and the clinical team. Relevant information is provided to the potential resident and their family to facilitate admission to the facility.

The residents' needs are assessed by the multidisciplinary team on admission and within the required time frames. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. The residents' files reviewed evidenced that the care provided, and the needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health providers as required. Shift handovers and communication sheets promote continuity of care between the shifts in the rest home and hospital and the dementia facility.

The planned activity programme is delivered by one full time diversional therapist and two part time activities assistants, spread across the three clinical areas. There is a separate programme for dementia residents which caters specifically for their unique needs, and one for rest home and hospital residents which provides a variety of individual and group activities and maintains the residents' links with the community. There is a facility van available for outings.

Medicines are managed according to the policies and procedures which are based on current best practice and consistently implemented. Medications are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with any special requirements catered for. There is food available for dementia residents 24 hours a day and snacks for rest home and hospital residents. Policies guide the food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with the meals provided.

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 environment meets the needs of residents and all areas inspected were clean and well maintained. There was a current building warrant of fitness. Electrical and medical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are maintained as safe and are accessible to all residents.

Waste and hazardous substances are well-managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are managed safely.

Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies. Fire evacuation procedures are regularly practised.

Residents reported a timely staff response to call bells.

Security is maintained.

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. |
|---|--|--|

The organisation has implemented policies and procedures that support the minimisation of restraint. There were no residents using restraints or enablers at the time of this audit.

Staff understood that the use of enablers is voluntary and only implemented at the individual's request and consent to use these.

When restraints are in use, past records and interviews confirmed that assessment, approval and a monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes and are provided with regular education.

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 prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed if required.

Staff demonstrated good knowledge around the principals and practice of infection control, guided by relevant policies and supported with regular education.

Age care specific infection surveillance is undertaken, with data analysed, benchmarked and results reported through to all levels of the organisation. Follow up action is taken as and when required.

Covid-19 related processes are in place to manage the changes in the Ministry of Health Covid-19 response levels.

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 | 1 | 92 | 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 | Wharerangi Rest Home & Village (Wharerangi) has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). This is displayed throughout the facility in both English and Māori and residents receive a copy of this in the admission pack. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is part of the ongoing "GEM" study days for all staff as this was verified in training records. |
| 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 | Nursing and care staff interviewed understood the principals and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs and outings. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents is defined and documented, as relevant, in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents' files reviewed in the dementia facility have an EPOA in place and have been activated. |

| | | |
|--|----|---|
| | | Staff were observed gaining consent for day-to-day care on an ongoing basis. |
| <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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the service are on display and available throughout the facility in both English and Māori. Family members and residents spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff were also aware of how to access the Advocacy Service if this is required. The Salvation Army Chaplin visits the facility and is available for both staff and residents to access.</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 assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities and entertainment. The facility encourages visits from family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed said they understood the process and would not hesitate to raise concerns if they had any. Residents are encouraged and supported to raise issues and concerns at their monthly meetings. There was evidence their feedback was taken into consideration and changes were made as a result.</p> <p>Oceania's process for complaints management is that all complaints are notified to support office who allocate responsibility for management and investigation. According to their job description the BCM is responsible for complaints management and follow up with input from the clinical manager and other team members if relevant.</p> <p>The complaints register recorded three complaints received in 2020 and two received this year. Documents and interviews related to these confirmed that each complaint had been acknowledged in writing, investigated and resolution achieved with all parties.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaint investigations by the office of the Health and Disability Commissioner, or the district health board since the previous surveillance audit in 2019.</p> |

| | | |
|--|----|--|
| | | |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>When interviewed, the residents and family/whānau of Wharerangi reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in English and Māori at the reception and throughout the facility and each resident has a copy of this in the admission folder. Information on how to make a complaint and provide feedback is available and displayed in the reception area.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>Residents and their families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to the personal cares of residents, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families. All residents have a private room with communal facilities. Six rooms have private ensuite facilities. There are several lounges located throughout the facility providing quiet areas to chat away from the main communal areas.</p> <p>Residents are encouraged to maintain their independence by participating in activities within the facility and outside in the community as Covid-19 allows. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs have been identified, documented and incorporated into their care plan. A memory wheel is situated in each of the residents' rooms which provides a quick point of reference for staff and residents.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to be occurring during the orientation and annually.</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</p> | FA | <p>There were 10 residents at Wharerangi that identified as Māori. Staff receive annual education to enable them to support residents who identify as Māori to integrate their cultural values and beliefs. This was evident throughout with the use of Te Reo Māori language on display. Residents often watch the Māori news with the diversional therapist encouraging those who speak Te Reo to</p> |

| | | |
|--|----|---|
| met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | | translate. The principals of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan and guidance on tikanga best practice is available. There are staff who identify as Māori in the facility and are able to act as a resource. |
| <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>Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Staff can access an external interpreter service for residents if required and several staff members are bi-lingual.</p> <p>Residents' personal preferences, required interventions and special needs were included in all care plans that were reviewed. For example, likes and dislikes and attention to preferences around activities of daily living. Residents' survey results evidenced that the residents' needs were being met.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | Residents and family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. One of the facility general practitioners who was interviewed also expressed satisfaction with the standard of services provided to the residents. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <p>The service provides and encourages good practice. This is demonstrated through evidence based policies, input from external specialist services and allied health professionals, for example, the hospice, wound care specialists, dieticians, podiatrist, and education for staff. The GP confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported that they receive management support for external education and access their own professional networks. Ongoing yearly training for RNs and care staff is provided both in house (GEM) study days, RN and carer study days, and education provided by external providers.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p> | FA | Residents and family members stated they were kept well informed about any changes to their own or their relative's status, they are advised in a timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the residents' |

| | | |
|---|----|--|
| provide an environment conducive to effective communication. | | <p>records that were reviewed. There was also evidence of resident/family input into the care planning process and the multi-disciplinary meetings.</p> <p>Staff understood the principals of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff knew how to access an interpreter should this be required, and several staff members are bi-lingual.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>The Oceania group develops an annual business plan with objectives and goals that each of its care facilities responds to. This is monitored for progress by the executive management team, from information provided by each of the facilities monthly business status report on identified indicators. The organisation's mission statement, vision and values are displayed at the entrance to the facility.</p> <p>Wharerangi is managed by a long term employed Business Care Manager (BCM) who is supported by a Clinical Manager (CM). The CM is an RN with a current practising certificate and extensive experienced in aged care. This person has held the role of a clinical manager since 2014 and previously worked at the same facility as an RN. The CM is stepping down and another long term employed senior RN is taking up the role in early October. Responsibilities and accountabilities are defined in their job descriptions and individual employment agreements.</p> <p>The BCM and CM confirmed knowledge of the sector, regulatory and reporting requirements and maintain their currency through attendance at conferences and study days. The management team is supported in their roles by the Oceania executive and the regional teams who maintain regular communication and monthly onsite assistance.</p> <p>The facility is certified to provide rest home/dementia and hospital level care to a maximum of 47 residents. There are 10 dedicated dementia beds and 37 dual purpose beds. On the days of audit there were 40 beds occupied which included one resident in public hospital. Of the 40 residents, nine required rest home level care, 21 required hospital level care and ten residents were in the secure/dementia wing.</p> <p>The request and subsequent approval from MoH to reconfigure three of the dual purpose beds to dementia beds was actioned. However lack of demand for these beds and challenges with space for the three extra residents in the common areas has proven to be unsafe so application has been made to revert back to the 10 dementia beds.</p> <p>The service has contracts with the DHB for the provision of rest home and hospital level care; respite care, long term support-chronic health care (LTS-CHC), and palliative care. There were no residents under the age of 65, and no residents receiving end of life care or being funded under the LTCS-CHC contract.</p> |

| | | |
|--|----|--|
| | | |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | FA | <p>As per Oceania policy, the BCM delegates their management responsibilities to CM with day to day support from the regional clinical manager (RCM) during any temporary absence. Cover for the CMs absence is allocated to a senior RN under the BCM's supervision. The organisation organises a qualified relief manager from the Oceania group to cover any prolonged absence of the BCM. Staff stated that senior management absences are well managed.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>Wharerangi follows the Oceania documented quality and risk management system which is well embedded in practice and reflects the principles of continuous quality improvement. The Oceania management group regularly reviews all its policies with input from relevant personnel and all policies were current at the time of this audit. Policies cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on currently known best practice. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>Service delivery is monitored through complaints, internal audit activities, regular resident and relative satisfaction surveys and the organisation's reporting systems which utilise a number of clinical indicators, such as incidents and accidents, surveillance of infections, pressure injuries, falls, and medication errors.</p> <p>Quality improvement data is collected, collated and analysed to identify trends. Where audits or quality data indicated the need for improvement, corrective action plans were developed, implemented, and evaluated before being closed out. There is communication with staff of any subsequent changes to procedures and practice through meetings and staff notices. A range of meeting minutes (quality/health and safety, RN, restraint, infection control and other staff meetings) confirmed how this information is reported and discussed with all levels of staff. Residents and family are notified of relevant updates via resident meetings or newsletters.</p> <p>Staff reported their involvement in quality and risk management activities through their participation on committees and with internal audits.</p> <p>Resident and family satisfaction surveys are conducted every six months. The most recent survey results from August 2021 had a 68% return from respondents and revealed high satisfaction with services. This was confirmed by the residents and family members interviewed.</p> |

| | | |
|--|----|--|
| | | <p>The organisation has a risk management programme implemented which records management of risks in clinical, environment, human resources and other areas specific to the facility. Health and safety policies and procedures are documented along with a hazard management programme. The hazard register sighted was current and is kept updated. Staff interviews confirmed an awareness of health and safety processes and the need to report hazards, accidents and incidents promptly.</p> <p>The BCM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and follows requirements. There have been no WorkSafe notifications since the previous audit</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>Staff document adverse and near miss events on an accident/incident form. Interviews and a sample of incident forms selected for review showed the resident's family had been notified where appropriate, an assessment had been conducted and observations completed. All incident forms are reviewed and where necessary investigated by the CM. There was evidence of actions being implemented to prevent recurrence where possible. These are then signed off as complete by the BCM.</p> <p>Analysis of incident data occurs monthly to identify facility trends and then data is benchmarked nationally with other Oceania facilities. Incidents/accidents are also discussed at quarterly regional cluster meetings. Specific learnings and results from incidents/accidents inform quality improvement processes. Meeting minutes confirmed that the BCM and CM share the results of incident analysis and discuss the impact of these at RN, quality/health and safety and staff meetings. Graphs which showed month by month trends and how this compares nationally are displayed in the staff room.</p> <p>The BCM and the CM described essential notification reporting requirements, including for pressure injuries. Documents showed there have been five section 31 notifications about pressure injuries made to the Ministry of Health, since the previous audit. Notifications for changes in governance, and executive and senior management have also occurred in a timely manner.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements</p> | FA | <p>Staffing management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the</p> |

| | | |
|--|----|--|
| of legislation. | | <p>orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation with competency assessments and periodic 'check in's' with new staff until they engage in their first annual performance appraisal.</p> <p>Wharerangi follows the Oceania approach to professional development which ensures that ongoing education is provided to all staff. Training records and interviews confirmed that all staff had undertaken a minimum of eight hours training each year which was relevant to their roles. Continuing education is planned and coordinated nationally each year. This includes role specific mandatory annual education and training modules that are provided via study days. Each facility also has the ability to implement other upskilling opportunities, such as using 'toolbox tutorials' and inviting in guest presenters for specific purposes. Evidence of this was demonstrated in the records for more in depth fire evacuation and safety training and with the series of sessions on Covid-19 training and the introduction of the facility specific easy to understand A-Z guide to managing a Covid-19 positive case. These examples are further discussed in standards 1.4.7 and 3.4.1.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Of the 29 HCAs currently employed, 15 have completed the national Certificate in Health and Wellbeing to level 4, one is at level 3 and 13 are still to commence the education. All HCAs who are rostered to work in the secure/dementia unit have completed the Level 4 - limited career pathway dementia modules. A number of staff members are identified as internal assessors for the Careerforce education programme.</p> <p>All RNs and a majority of care staff, the activities staff and other allied health staff are maintaining first aid certification. All RNs, the CM and senior HCAs undergo annual medication competencies.</p> <p>All of the six RNs employed are maintaining their interRAI competencies.</p> <p>Education session attendance records showed that ongoing education is provided in topics relevant to the services delivered. The electronic training register (LMS) readily identifies individual staff who are due to complete their required training and competencies. These include subjects such as: fire training; infection control; hoist use; restraint; medication management; and wound management. Each of the staff records sampled contained evidence that training and annual performance appraisals were up to date.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p> | FA | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). This meets the minimum requirements of the DHB contract. Interviews and rosters confirmed that staff levels are adjusted to meet the changing needs of residents. There is a small casual pool of HCAs available to supplement</p> |

| | | |
|--|-----------|---|
| <p>suitably qualified/skilled and/or experienced service providers.</p> | | <p>rosters when needed to accommodate increases in workloads. The CM is available on call after hours, seven days a week. Staff reported that reliable access to advice is available when needed.</p> <p>Care staff and RNs said there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover is provided to meet current residents' acuity and bed occupancy, with staff replaced in any unplanned absence. Residents' needs were being consistently met in a timely manner. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage to meet the ARC requirements for hospital level care.</p> <p>Wharerangi employ 49 staff including the management team, RNs, health care assistants (HCAs), a diversional therapist (DT) and activities assistant and household staff, such as kitchen, laundry and cleaning staff who provide services seven days a week.</p> <p>Rosters sighted reflected adequate staffing levels and showed there is at least one RN on site every morning and afternoon shift. There are seven HCAs allocated for morning shifts (varying hours) and six HCAs (varying hours) for the afternoon shift. There is one RN on each night shift who is supported by two experienced HCAs. Protocols for responding to the onsite village residents' call bell activations, is that the RN determine by phone if an HCA needs to attend or whether to contact an ambulance. The BCM stated there are on average five call bell activations from village residents each year. The sole night-time RN understands they are not to leave the building to attend to these.</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> | <p>FA</p> | <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records are legible with the name and designation of the person stamped beside the entry.</p> <p>Archived records are held securely on site for 12 months and are readily retrievable. They are then transferred offsite and held for the required period of time before being destroyed. No personal or private resident information was on display during the audit.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been</p> | <p>FA</p> | <p>Residents are admitted to Wharerangi following assessment from the Lakes Needs Assessment Service (NASC), as requiring the level of care that Wharerangi provides. For those residents in dementia care, all appropriate consents were in place and signed by the EPOAs as was the admission agreement. Specialist authorisation for placement was sighted and, in the files, viewed. Prospective residents and their families are encouraged to visit the facility prior to admission and are</p> |

| | | |
|--|----|---|
| identified. | | <p>provided with written information about the service and the admission process. All residents are admitted to the facility in accordance with current MoH Covid-19 guidelines.</p> <p>Family members interviewed stated that they were happy with the admission process and the information that had been provided to them. Files reviewed contained the completed demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner. The service uses the Lakes DHB 'Yellow Envelope' system to facilitate the transfer of residents to and from acute care settings and 'pink' envelopes for palliative care. There is open communication between all services, the residents, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, is provided for ongoing management of the resident. All referrals are documented in the progress notes.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | FA | <p>The Medication Management Policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Two RNs or one RN and one medication competent carer sign in the medications against the prescription, then sign and date each blister pack. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries with controlled drugs signed in. All registered nurses are competent with syringe drivers.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of temperature records taken at the time of the audit.</p> <p>Good prescribing practices were noted. These included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine</p> |

| | | |
|---|----|--|
| | | <p>chart. There are no standing orders or verbal orders. Vaccines are not stored on site. Residents and staff have received the required Covid-19 vaccines with the exception of those who did not want to be vaccinated.</p> <p>There is a documented process for any residents who are self-medicating this is decided in conjunction with the GP, RN and the resident. Self-medication documentation is completed by the GP and a copy is placed in the notes. At the time of the audit there were no residents self-administering medications.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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 food service is provided on site with a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician on 17 May 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries (valid until 28 March 2022). At the time of the audit, the kitchen was observed to be clean. The cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored and recorded as part of the plan using a paper base recording system.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and families/whānau interviews, satisfaction surveys and in residents' meeting minutes. There are snacks available twenty hours a day for residents and in the dementia service with facility trays of sandwiches also made. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is</p> | FA | <p>If a referral is received, but the resident does not meet the entry criteria, there are no vacancies, or the referral has been declined from the service due to inappropriate referral from the NASC service, there is a process in place to ensure that the prospective resident and family are supported to find an</p> |

| | | |
|--|----|--|
| declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | | <p>appropriate level of care. Examples of this occurring were discussed with the clinical manager.</p> <p>If the needs of the resident change and they are no longer suitable for the services offered a referral for reassessment is made to the NASC and a new placement is found in consultation with the resident and the whānau/family.</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>On admission, residents are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, cognition and behaviour, nutrition and activities, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents (except for respite, ACC and YPD residents) are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>Those long term residents not being assessed using the interRAI assessment tool have clinical assessments to inform care planning. These are reviewed every six months or if the resident's needs change.</p> <p>Interviews, documentation, and observation verified the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs.</p> <p>All residents have current interRAI assessments completed by one of the trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</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 at Wharerangi are documented on a computerised patient documentation system. When reviewed this reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly documented, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. The files reviewed in the dementia facility each had a detailed 24 hour behavioural plan in place specific to the resident's individual needs. Residents and family/whānau reported participation in the development and ongoing evaluation of care plans.</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>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The GP interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the GP should a resident's condition change. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources were available and suited to the levels of care provided and in accordance with the resident's needs.</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> | FA | <p>The activities programme is provided by one full time qualified diversional therapist who supports the rest home, hospital and dementia residents Monday to Friday 8.30am till 5.00pm. They are supported with two part time activities assistants/carers who work at the weekends 8.30am till 3.00pm in the facility and assist during the week.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated daily and documented once a week and as part of a six monthly multidisciplinary care plan review.</p> <p>Residents in the dementia facility have an in depth 24 hour diversional therapy plan and an assessment on admission to enable the staff to better care for them and understand their needs. There are ten residents who identify as Māori, and they are greeted in their native tongue and support is given for activities culturally appropriate for them. It is the aim of the diversional therapists to get the residents engaging in the community as much as possible. There is a facility van available for drives on a Wednesday and Thursday for rest home and hospital residents and a Thursday morning for residents with dementia.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'Housie', knitting and visiting entertainers. There are individual, group and gender specific activities for female and male residents. Hospital and rest home residents have a separate activity programme from the dementia residents. There are several lounge areas, as well as the individual's bedrooms where residents have the opportunity to watch their own television or listen to the radio. The Activities Calendar is on display and each resident is given a copy of the monthly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular basis.</p> <p>Residents and families can evaluate the programme through day to day discussions with the</p> |

| | | |
|---|----|--|
| | | activities co-ordinator and by completing the six-monthly resident satisfaction survey and the six monthly multi-disciplinary meeting. Residents interviewed confirmed the programme was interesting and varied. |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Resident care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI/clinical reassessment or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans were consistently reviewed for infections, pain, and weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in the residents' files, including to the Lakes NASC for re-assessment of a resident. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as ringing an ambulance if the situation dictates.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and to provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment which staff were observed to be using during the audit.</p> |

| | | |
|---|----|--|
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>A current building warrant of fitness (expiry date 31 May 2022) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Evidence that this occurs was confirmed in documentation reviewed, interview with the maintenance manager and observation of the environment. There is an extensive monthly planned maintenance schedule which is reliably attended to maintenance personnel. Testing and tagging of electrical equipment is carried out by the full time employed maintenance person who is a registered electrician. Testing and calibration of bio medical equipment occurred in April 2021. The environment was hazard free and resident safety was promoted. External areas were confirmed as being safely maintained and were sighted as appropriate to the resident group and setting. Indoor and outdoor areas allow for purposeful and easy walking. Residents and family members were happy with the environment</p> <p>Staff and residents said they knew the processes to follow when repairs or maintenance are required and said their requests are actioned in a timely way. This was confirmed by sighting entries in the maintenance request book and interview with maintenance staff.</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> | FA | <p>There were adequate numbers of accessible bathroom and toilet facilities throughout the facility. There are six ensuite bedrooms with a fully accessible bathroom and toilet, ten other toilets plus two staff toilets and a visitors' toilet and eight bathrooms for residents to use. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>Hot water temperature testing occurs regularly, and the records showed that all water temperatures were within a safe range, for example, no higher than 45 degrees Celsius in resident accessible areas and slightly higher than 60 degrees Celsius in the kitchen and laundry.</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> | FA | <p>Adequate personal space is provided to allow residents and staff to move around and within their bedrooms safely. Each of the 47 bedrooms provide for a single occupant. All bedrooms are located on the ground floor and allow easy access to ablutions and recreational and dining areas. Rooms are personalised with furnishings, photos and other personal items displayed.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And</p> | FA | <p>A variety of communal areas are available for residents to engage in activities. There is a large dining room and lounge centrally located to enable easy access for residents and staff. The secure</p> |

| | | |
|--|----|---|
| <p>Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | | <p>unit has its own dining and lounge area. There are sufficient private and quiet spaces available in other areas of the facility for residents to access for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | FA | <p>Laundry is undertaken on site by dedicated laundry staff who are on site seven days a week. Laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>All designated laundry and cleaning staff have attended training in safe chemical handling as confirmed in interview with staff and their training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. There are cleaners on site seven days a week. One cleaner works Monday to Friday for five a day and the weekend laundry person carries out basic cleaning on Saturday and Sundays for five hours a day.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. The chemical provider who visits regularly also provides staff education/information and tests the effectiveness of their products.</p> <p>There have been no issues, complaints or staff injury related to cleaning and laundry.</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>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff.</p> <p>Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The fire evacuation plan was approved by the New Zealand Fire Service in 2009. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 07 September 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. The BCM updated and trialled a new fire safety site specific questionnaire for staff in 2020, because staff were either copying each other's answers or incorrectly answering the questions. This achieved the desired result with all staff saying the new questionnaire was easy to use and made more sense to them.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs, were sighted and meet the National Emergency Management Agency recommendations for the region. Water storage tanks and potable water is located around the</p> |

| | | |
|---|----|---|
| | | <p>complex, and there are effective systems for managing power outages. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. There have been no concerns about security reported.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All residents' rooms and communal areas are heated and ventilated appropriately. All bedrooms have appropriately sized opening external windows which provide sufficient natural light.</p> <p>Heating in residents' rooms and in the communal areas is provided underfloor by gas fired boilers. There are additional plug in heaters and plans to install heat pumps in rooms and areas located on the south side of the building.</p> <p>All areas were warm and well ventilated throughout the audit and residents and families confirmed that the home is maintained at a comfortable temperature regardless of the weather.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>Wharerangi implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. A comprehensive and current infection control manual is available to staff and managers. There was evidence that formal reviews of the programme are completed annually.</p> <p>The registered nurse is the designated infection prevention and control co-ordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and reviewed at the monthly quality committee meetings. Infection prevention and control matters are also discussed at registered nurse meetings, staff handovers, staff meetings and ultimately at management meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities and confirmed this had been further reinforced since the Covid-19 pandemic emerged with a documented process for each of the alert levels.</p> <p>Staff and management have gone beyond what is normally expected with developing a Covid-19 resource to empower staff to feel confident should the need arise with Covid-19 positive resident,</p> |

| | | |
|--|----|---|
| | | resulting in a continuous improvement rating. |
| <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 ICN has the appropriate skills, knowledge and qualifications for the role. Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the GP and the public health unit, as required. The co-ordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>There is a Covid-19 management plan in place which details all the actions required by the service stream within the facility in response to each of the alert levels. The ICN and the quality manager confirmed the availability of resources to support the programme and any outbreak of an infection.</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>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing and clearly documents on each policy the next review date.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are distributed around the facility.</p> <p>Staff interviewed verified knowledge of infection control policies and practices.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and in ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response.</p> |
| Standard 3.5: Surveillance | FA | <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract and skin infections.</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>When an infection is identified, a record of this is documented in the resident's clinical record. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plans are discussed at shift handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at staff meetings and during shift handovers. A good supply of personal protective equipment was available. St Johns Wood has processes in place to manage the risks imposed by Covid-19.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>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 RN/restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>The restraint register showed there had been no restraints or enablers in use since July 2021.</p> <p>The restraint coordinator described the various alternatives to restraint in use and said that restraint was used as a last resort when all alternatives have been explored. This was evident on observation of the environment, review of the restraint approval group minutes, files reviewed, and from interviews with staff.</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, 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 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management. | CI | Staff expressed feeling ‘overwhelmed’ with managing any future Covid-19 cases even though they were doing what was expected and utilising the information and resources they had available. Facility senior management developed an easy to understand A-Z guide to assist staff with managing a positive Covid-19 case. The guide contained a one-page checklist relevant to each specific area, Ministry of Health data sheets and prescribed statements and emails for families and agencies outside of the organisation. Instruction/education was provided about where on the database staff should file documents, links to relevant sites, protocols for staff allocations of residents, and work flows for managing a positive case. Staff described feeling re-assured, safe and knowledgeable about managing a positive Covid-19 case. | The site specific easy to understand Covid-19 guide has succeeded in ensuring all staff feel more confident and competent in safely managing any positive Covid-19 cases and being able to capably explain this to residents and their families so they understand how this will be managed. The resource was developed in July and reviewed in September. |

End of the report.