

Holmbridge Holdings 1852 Limited - Wakefield Homestead

Introduction

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

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

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

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

The specifics of this audit included:

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| Legal entity: | Holmbridge Holdings 1852 Limited |
| Premises audited: | Wakefield Homestead |
| Services audited: | Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 19 November 2021 End date: 19 November 2021 |
| Proposed changes to current services (if any): | Nil |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 22 |

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

General overview of the audit

Wakefield Homestead is privately owned and operated and provides rest home level care for up to 22 residents. On the day of the audit there were 22 residents. The residents interviewed spoke highly of the service and care provided at Wakefield.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, management, staff, general practitioner, and other allied health professionals involved in the care of the residents.

The two owners have owned the facility for four years. The non-clinical facility manager (owner) has previous experience owning and operating an age care facility. The other owner is the health and wellbeing manager (registered nurse) who has experience in age care. They are supported by a team administration and non-clinical staff and long-standing caregivers.

There are quality systems and processes being implemented. There is a clear resident focus and staff know the residents well. Residents are supported to maintain links in the community.

This audit identified three shortfalls around staff files, education, maintenance, and documentation of fire drills.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Policies are documented to support resident rights. Systems protect their physical privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained.

Consents are documented by residents or family and there are advance directives documented.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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There are policies and procedures to provide appropriate support and care to residents with hospital and rest home level needs. The annual business plan includes values, scope, and strategic direction, goals are reviewed regularly throughout the year. The quality and risk management programme that includes analysis of data. Combined meetings are held at regular intervals to discuss quality and risk management and to ensure these are further embedded into practice. There is a health and safety management programme that is implemented with evidence that issues are addressed in a timely manner.

An orientation programme is in place. The service is implementing an online education platform.

Rosters and interviews indicate sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs. A roster provides sufficient and appropriate coverage for the effective delivery of care.

The residents' files are appropriate to the service type.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Standards applicable to this service fully attained. |
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The registered nurse is responsible for the assessment, development, and evaluation of care plans. There is evidence of resident/relative input into care plans. The care plans are resident, and goal orientated. Files reviewed identified integration of allied health and a team approach is evident in the overall resident file. There is a three-monthly general practitioner review. Residents interviewed confirmed that they were happy with the care provided and the home-like environment.

Planned activities are appropriate to the residents' assessed needs and abilities. Residents confirmed satisfaction with the activities programme. Residents are involved in community events and activities. There are regular entertainers and van outings.

There is a documented medication management policy and procedure at the facility. All medications are stored safely. The service uses an electronic medication system.

Residents' food preferences and dietary requirements are identified at admission and all meals cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The building holds a current warrant of fitness. There is a reactive maintenance system. There has been refurbishment of the facility in communal areas and resident bedrooms.

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings, and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system.

Documented systems are in place for essential, emergency and security services. There is an approved evacuation scheme and emergency supplies available. There are staff on duty 24/7 with a current first aid certificate.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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Wakefield Rest Home has restraint minimisation and safe practice policies and procedures in place. There was one resident with a lap belt restraint and no residents using enablers. Restraint documentation is completed as required. Staff receive training in restraint minimisation and challenging behaviour management.

Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |
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The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (registered nurse) is responsible for coordinating and providing education and training for staff. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking within the age care sector through the electronic resident management system.

Policies, procedures, and the pandemic plan has been updated to include Covid 19. Adequate supplies of personal protective equipment were sighted during the audit. Staff were knowledgeable around isolation procedures. 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 | 47 | 0 | 1 | 2 | 0 | 0 |
| Criteria | 0 | 96 | 0 | 4 | 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) |
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| 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 |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented and staff interviewed (two caregivers, one diversional therapist, one maintenance, one human resources (HR) assistant, one chef, one kitchen hand) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which is planned annually through the staff education and training programme (link 1.2.7.5).</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA | <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. A multipurpose informed consent form is utilised by the service provider and is retained in each individual resident's record reviewed. Forms are signed and dated appropriately. The admission agreements were signed and dated by the provider and the resident and/or representative.</p> <p>The GP interviewed understood the obligations and legislative requirement to ensure competency of residents as required for advance directives and advance care planning. Resident reviews were undertaken three-monthly. Reviews of the individual resident's health status were documented and</p> |

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| | | <p>retained in each personal file reviewed.</p> <p>There are policies in place for informed consent and resuscitation and the service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Discussions with staff confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms.</p> <p>Discussion with residents confirmed that the service actively involves their relatives in decisions that affect their lives, where they consent to this.</p> |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>Information on advocacy services is included in the resident information pack that is provided to new residents and their family on admission. Advocacy brochures are also available at reception. Interviews with residents and staff confirmed their understanding of the availability of advocacy services.</p> <p>Age Concern visits the facility and provide staff education and provide an opportunity for the residents to discuss concerns if required. The complaints process is linked to advocacy services with this offered to any complainant if required.</p> <p>Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service with training records confirming this.</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>Links with the community are encouraged and residents are supported to go shopping in the community and attend local groups of their choosing. Until the last Covid level 4 lockdown there were frequent visits from school children, and residents visited the school. The management team are supportive of entertainers and visitors visiting the facility in line with the current Covid 19 regulations. During the audit, residents went out on a bus outing, and were seen going out with visitors. Residents confirm relatives can usually visit at any time as Covid 19 restrictions allow.</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 organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The facility manager is responsible for complaint management in consultation with the health and wellbeing manager.</p> <p>A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available at the entrance to the facility. There is a complaints' register that includes relevant information regarding the complaint.</p> <p>Residents interviewed stated that they felt they could complain at any time and those that had, stated that</p> |

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| | | <p>their concerns had been dealt with in a timely manner to their satisfaction. There has been one complaint forwarded by the DHB who stated that this was not about the rest home directly. There were no issues identified. There have been no other complaints made since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. On admission, the health and wellbeing manager (RN) discusses aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are also held during the monthly resident and three-monthly family meetings. The five residents interviewed confirmed that they received cares that met their needs, and all were aware of their rights. There were no family members available for interview during the audit.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>The residents' personal belongings are used to decorate their rooms. All toilets and bathrooms have locks to ensure privacy.</p> <p>The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed to occur during the audit. Caregivers reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents interviewed confirmed that residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. Incidents were reviewed for 2021 and there are no incidents around abuse. Staff, and the general practitioner interviewed confirmed that there was no evidence of abuse or neglect.</p> <p>Spiritual needs are individually identified as part of the assessment and care planning process.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural,</p> | FA | <p>There is a Māori health plan with goals to improve outcomes for residents. The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident.</p> <p>There was one resident living at the facility who identify as Māori but does not affiliate with their culture. Staff receive annual education on cultural awareness and the principles of Tiriti O Waitangi that begins during their induction to the service. Signage has been upgraded to include Te Reo and English</p> |

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| values and beliefs. | | language. The service has access to support through the Māori Health Unit at the district health board if required. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. Staff interviewed confirmed that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the care plan as sighted in the review of resident records reviewed. Residents interviewed confirmed they are involved in developing their plan of care, which includes the identification of individual values and beliefs. |
| Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents. Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment, or financial exploitation. Professional boundaries are reconfirmed through staff meetings, the managers stated that performance management would address any concerns if there was discrimination noted. |
| Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard. | FA | The service meets the individualised needs of residents with needs relating to rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. The service is going paperless. The electronic resident management system has been fully embedded which includes incident reporting and monitoring. A new human resources (HR) system is in the process of being implemented which manages health and safety and HR files. The service has recently employed an HR assistant who is implementing the HR system and managing rostering. An online system has recently been implemented to provide an online education platform for staff to complete education sessions at a time that suits them. The health and wellbeing manager is working with the online education company to align education with New Zealand requirements. There have been continued refurbishments throughout the facility including an upgrade of the emergency systems and call bell system. The flower gardens are established, which include a range of plants used for complimentary therapies. Combined quality and staff meetings which incorporate health and safety, and infection control are held regularly. Staff interviewed report they are updated of current changes of |

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| | | <p>residents' condition at each handover.</p> <p>Residents interviewed spoke positively about the care and support provided. Staff interviewed stated that they feel supported by the management team. The manager reports a low staff turnover.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents interviewed confirmed they were given an explanation about the services and procedures and were orientated to the facility as part of the entry process. They also stated their relatives are informed of changes in health status and incidents/accidents with family interviewed confirming that they were kept informed at all times. A review of three recent incident forms confirmed that family were informed in a timely manner when incidents occurred.</p> <p>Resident meetings have occurred regularly which relatives are invited to attend. Residents confirmed that they find the meetings useful and provide opportunities to raise issues or concerns. The residents confirmed that the managers have an open-door policy and are prompt at dealing with concerns as observed during the audit.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available through the district health board with phone numbers identified in policy. There are no residents currently requiring the use of interpreting services.</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>Wakefield Rest Home is privately owned and managed by the on-site facility manager and the health and wellbeing manager/RN for four years. The service provides care for up to 22 residents. On the day of audit there were 22 rest home residents, including one younger person with a disability (YPD) and one resident on the long-term support- chronic health contract (LTS-CHC).</p> <p>This family-orientated service has a current business plan that includes the vision, values, and philosophy of care "family caring for family". Residents interviewed were very happy with the care and the homely environment including the pet friendly environment. The annual quality plan includes goals to monitor the quality/risk system and refurbishments to the facility. The goals have been reviewed regularly and involve the staff.</p> <p>The facility manager has a qualification in social work in health management and had owned another small rest home in the area. The health and wellbeing manager is an experienced registered nurse (RN) with over 20 years of experience in the aged care industry. They are supported by an administrative assistant, HR assistant, a maintenance person, and legal advisor. They have professional affiliations</p> |

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| | | <p>with two aged care consultants.</p> <p>The managers have both completed at least eight hours of professional development.</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>The facility manager reported that in the event of her temporary absence the health and wellbeing manager/RN fills the role with support from care staff.</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>There is an established quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Any issues arising from internal audits are developed into corrective action plans with evidence of resolution of issues as these are identified. Monthly reports are collated from the resident management system around any incidents, (falls, skin tears etc), and infections. Results are collated and reported at the monthly at the combined quality/ staff/ health and safety/ infection control/ restraint meeting. The service also collates benchmarking data from the age care sector through the electronic resident management system. If any staff are not able to attend the meeting, minutes and graphs are available for staff to read and sign once read.</p> <p>The annual residents/relatives survey for the service, both the 2020 and 2021 evidenced overall satisfaction with the service with high numbers very satisfied or satisfied with all aspects of the service. No corrective actions were identified.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. There is a health and safety plan with evidence of review at the health and safety meetings. The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a health and safety</p> |

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| | | <p>competency completed by staff as part of orientation (staff records confirmed that these had been completed). Workplace health and safety is included in the education planner and training has been completed annually. A current hazard register is available in the nurse's station and is reviewed regularly. Staff interviewed were aware of hazard reporting processes and could easily describe hazard management and minimisation.</p> <p>Falls prevention strategies include the use of sensor mats. Individualised falls prevention strategies are documented on residents' files accordingly.</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>Incident and accident data is being collected and analysed. The rate of incidents are minimal at Wakefield Homestead, as evidenced in monthly reports. A review of three incident/accident forms that occurred in September to November 2021 identified reports were all fully completed, including follow-up by a registered nurse and that family had been notified. Post-falls assessments included neurological observations for one unwitnessed fall reviewed were completed as per policy. Near misses are also reported through the incident reporting system.</p> <p>The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring, and corrective action to minimise and debriefing. Data is linked to the benchmarking programme and used for comparative purposes. Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications are completed as required and since the last audit, there has been one notification made around a resident absconding.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | PA Moderate | <p>There are human resources policies to support recruitment practices. Six staff files were reviewed (one health and wellbeing manager/ registered nurse, the diversional therapist, the cook, and two caregivers). The service is in the process of changing over to an electronic HR/ health and safety system. All staff files are now electronic, however, not all documentation was evident on the electronic files.</p> <p>Performance appraisals have been completed annually. Copies of annual practising certificates are on file.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were orientated well to the service. The orientation programme includes a buddy system with the new member of staff working alongside an experienced member of staff in the same role. Care staff complete competencies as part of orientation relevant to their role.</p> <p>Core competencies are completed, with a record of completion maintained. Staff interviewed were aware</p> |

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| | | <p>of the requirement to complete competency training.</p> <p>The service is in the process of implementing an online education platform, the health and wellbeing manager is working alongside the company to align education session to New Zealand requirements. Staff are now completing education online, however, not all compulsory sessions have been completed within the last two years.</p> <p>Caregivers are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications through Careerforce. There is a total of 13 caregivers, four have achieved level 4, three have achieved level 3, and one has achieved level 2 NZQA.</p> <p>The enrolled nurse has recently left her position, the service is currently recruiting to fill the position. The health and wellbeing manager is interRAI trained and has access to external education through the DHB and Hospice.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>Wakefield Homestead has a weekly roster in place, which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs and allow for one-on-one time with residents as observed during the audit. The facility manager and health and wellbeing manager/RN are on site during the day from Monday to Friday and are on-call 24/7 for any operational and clinical issues respectively. Roster shortages or sickness are covered by existing staff. There is a very stable workforce, the management report a low turnover of staff.</p> <p>Each shift as one senior caregiver who has a first aid certificate and is medication competent.</p> <p>On morning shift, there are three caregivers rostered; 1x 7am to 3pm (senior), 1x 7.30am to 3.30pm, and 1x 8am to 11am (Monday to Friday only). The afternoon shift has one caregiver from 3pm to 11.15pm (senior) and one caregiver from 3.30pm to 9pm. Nightshift is covered by one senior caregiver.</p> <p>Other dedicated staff include a cleaner, cook, kitchenhand, diversional therapist, HR assistant, admin assistant and one maintenance.</p> <p>Residents stated there were adequate staff on duty. Staff stated they feel supported by the facility manager and health and wellbeing manager/RN who respond quickly to afterhours calls.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> | FA | <p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24-hours of entry into each resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised</p> |

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| <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | | <p>access and are password protected. Archived records are secure in locked areas.</p> <p>Residents' files demonstrated service integration. Entries are legible, dated, timed, and signed by the relevant caregiver or nurse, including designation.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | <p>FA</p> | <p>The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements were signed in all resident's sampled records. Admission agreements reflect all the contractual requirements. Residents and families reported that the admission agreements were discussed with them in detail by the facility manager or health and wellbeing manager.</p> <p>All residents had the appropriate needs assessments prior to admission to the service. The service has specific information available for residents/families/EPOA at entry and it included associated information such as the Health and Disability Code of Rights, advocacy, and complaints procedure. The admission agreement reviewed aligned with the ARRC contract and exclusions from the service were included in the admission agreement.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | <p>FA</p> | <p>There are policies to describe guidelines for death, discharge, transfer, documentation, and follow-up. A record is kept, and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The registered nurse verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the service.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The RN, and medication competent caregivers administer medications. Monthly regular medications and 'as required' medications are delivered in blister packs. Medications are reconciled on delivery by the RN and checking for each pack is entered into the electronic medication system. Any pharmacy errors are recorded and fed back to the supplying pharmacy All medications in stock are prescribed for residents. There are no standing orders. There are three self-medicating residents (inhalers) who have self-medication competencies and related required documents completed. Staff check that residents take medications. The medication fridge and room air temperatures are monitored daily.</p> <p>Ten electronic medication charts were reviewed. All residents have individual medication charts with photo identification and allergy status documented. Medication charts have been reviewed three-</p> |

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| | | <p>monthly. The effectiveness of 'as required' medications had been documented in the electronic system.</p> <p>Education on medication management has occurred with competencies conducted for support workers with medication administration responsibilities.</p> <p>Ten electronic medication charts were reviewed. All residents have individual medication orders with photo identification and allergy status documented on the electronic medication system and all had been authorised (signed) by the GP and reviewed three-monthly. The medication chart was signed each time staff administered a medicine.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>All food is prepared and cooked on site at Wakefield Rest Home. There is a qualified chef and kitchenhand on duty each day. The main meal is at midday and the evening meal is pre-prepared for care staff to reheat and serve. Staff have received food safety training. There is a four-weekly rotating menu. The service provides meals-on-wheels to the community. The summer menu has been reviewed by a registered dietitian. Meals are served directly to residents in the adjacent dining room. The cook receives notification of any resident dietary changes and requirements. Dislikes and food allergies are known and accommodated, and alternative foods offered. Special diets include soft modified diets, diabetic, gluten free, meat free, dairy free and vegetarian.</p> <p>There is a current food control plan in place - expiry date 31 December 2021. Fridge, chiller, and freezer temperatures were recorded daily. End-cooked food temperatures had been taken and recorded daily. Thermometers are calibrated regularly as required. A cleaning schedule is maintained. All dry goods had expiry dates, stored in containers with lids on and stored off the floor.</p> <p>Residents interviewed were very satisfied with the meals. They have the opportunity to provide feedback on the menu at the resident meetings and annual survey. The chef and kitchenhand interact frequently with residents.</p> <p>The meals were well-presented, and residents confirmed that they are provided with alternative meals as per request. There were no residents with unintentional weight loss</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is</p> | <p>FA</p> | <p>Wakefield rest home records the reason for declining entry to potential residents should this occur and communicates this to potential residents/family/whānau and refers them back to the referral agency. The reason for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p> |

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| managed by the organisation, where appropriate. | | |
| <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>All residents are admitted with a care needs level assessment completed by the need's assessment and service coordination team prior to admission. Personal needs information is gathered during admission which formed the basis of resident goals and objectives. Assessments are reviewed at least six-monthly. Appropriate risk assessments had been completed for individual resident issues. The health and wellbeing manager has completed interRAI training and the assessment tool was evident in resident files and linked to long-term care plans.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Resident files included all required documentation. The long-term care plans sampled were completed within three weeks of admission and were resident-focused and personalised. Interventions included support for current needs. Short-term care plans are developed where needed and were evident in the sampled files. Care plans reviewed had been evaluated for identified issues and were completed six-monthly, or as condition changed. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Families interviewed confirmed their involvement in the care planning process. Short-term care plans are in use for short-term needs and all infections and changes in health status. Staff members reported they are informed about changes in the care plans. Integration of records and monitoring documents are managed.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>When a resident's condition changes the RN initiates a GP visit. Family members are notified of any changes to the residents' health. Care plans are current, and interventions reflect the assessments conducted and the identified requirements of the residents. Residents interviewed stated their expectations were being met. There were no relatives visiting on the day of the audit.</p> <p>An electronic wound assessment, wound management plan and evaluations were in place for one resident with two skin tears. The size of the wounds is measured, and photos taken. Dressings are changed as per the documented frequency. There was evidence of the management of previous skin tears. There were no current wounds managed including pressure injuries and chronic wounds. The district nurses are readily available for wound advice if required. The service uses home-made ointment and oils to improve residents skin integrity. The application of topical alternative therapies is applied with written resident consent and are charted by the GP as alternate therapies. They do not replace prescription treatments.</p> <p>Continence products were available and resident files included a urinary continence assessment, bowel management, and continence products identified for use. Specialist continence advice was available as</p> |

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| | | <p>needed and this could be described.</p> <p>Monitoring occurs for weight, observations (blood pressure and pulse), blood glucose, bowel record, food and fluids, behaviours, and restraint monitoring. There is a daily scheduled intervention list for each resident on the electronic resident file. Progress notes reflect daily interventions and key information. The wellbeing manager/RN and stated staff promptly report any resident changes or concerns.</p> <p>Care plans are current, and interventions reflect the assessments conducted and the identified requirements of the residents. Interviews with staff (registered nurse and caregivers) and residents confirmed involvement of families in the care planning process. Caregivers, and the RN interviewed, stated there is adequate equipment provided including continence and wound care supplies. Visual inspection confirmed that continence products were available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice was available as needed and this could be described. Wound assessment and wound management plans were in place for three previous skin tears, evaluations occurred as required and dressing changes were documented as scheduled.</p> <p>Monitoring occurs for weight, vital signs, blood glucose and 'as required' for nutritional intake and behaviour. Neurological observations are completed for unwitnessed falls or for suspected head injury following a fall.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The activity coordinator has been in the role for five years and works Monday to Friday for 17 hours a week. The programme is planned over a five-day week and times vary according to the activity. The hours are flexible to accommodate activities and events outside of her normal working hours. The activity coordinator is progressing through the diversional therapy (DT) course and attends the regional DT meetings. There is a morning programme Monday to Friday and an afternoon programme three afternoons a week. The programme is planned monthly and additional activities are supported by the caregivers. There are available resources including puzzles, DVDs, and books. A weekly programme is displayed. There are several volunteers and staff volunteers who assist with activities and outings.</p> <p>Activities include (but not limited to), exercises, bingo, bowls, walks, crafts, quizzes, and happy hours. There are musical entertainers weekly. Church services are held fortnightly rotating between three local churches. There are outings into the community such as events at the Anglican church and community lunches. There are weekly van outings to places of interest, scenic drives, and shopping. The activity coordinator has a current first aid certificate.</p> <p>There is one-on-one time spent with the younger people and a volunteer takes residents out to cafés and for walks. The residents choose group activities they would like to attend and are supported to attend community activities of their choice. One resident has been supported to attend animal assisted therapy.</p> |

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| | | <p>Some residents assist with setting the tables, taking bins out and help with recycling.</p> <p>Each resident has an individual activity assessment, and an activity plan is included in the electronic long-term care plan which is evaluated every six months. Residents have the opportunity to feedback on the programme at the two monthly resident meetings or at any time. Residents interviewed were happy with the activities offered.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Long-term care plans were reviewed and evaluated every six months or earlier as required in the electronic files reviewed. The long-term care plans had been evaluated against goals and outcomes and updated with changes to care. The residents and family members reported they were involved in all aspects of care and reviews/evaluations of the care plans.</p> <p>There is documented evidence in progress notes of family involvement in care plan evaluations. Care staff are asked for input into the care plan evaluation.</p> <p>The family are notified of GP visits and three-monthly reviews by phone call and if unable to attend, they are informed of all the changes. There is at least a three-monthly medical review by the medical practitioner.</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>There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and the families are kept informed of the referrals made by the service. The RN facilitates internal referrals.</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</p> | FA | <p>All chemicals were securely stored on the day of audit. Maintenance staff advised that all chemical storage areas both inside and outside were locked when not in use. Chemicals were clearly labelled, and safety material datasheets were available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they can access personal protective clothing and equipment at any time. As observed during the audit, staff were wearing gloves, aprons and hats when required. Review of staff training records and interviews with caregivers confirmed that regular training and education on the safe and appropriate handling of chemical and waste and hazardous substances occurs.</p> |

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| substances, generated during service delivery. | | There is a slice next to the laundry with protective eyewear, gloves, and aprons. |
| <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> | PA Moderate | <p>The building is single level and divided into two wings Betty wing (10 beds) and John wing (12 beds).</p> <p>There is a current building warrant of fitness that expires 19 April 2022. The last recorded fire drill and notification occurred in July 2020 (link 1.4.7.1). A maintenance person addresses day to day repairs and completes the maintenance requests in a timely manner and sign off the maintenance book when completed. There was no evidence of an annual preventative maintenance plan and hot water temperatures have not been consistently monitored. Testing and tagging of electrical equipment has been completed in March 2021.</p> <p>There has been ongoing refurbishment and upgrades in the homestead including painting, wallpapering, overhaul of electrical wiring and lighting, replacement of fans in communal bathrooms and toilets, upgrade of medication/treatment room and new window furnishings.</p> <p>Communal areas are spacious and comfortable for the residents. There is a fish tank and a pool table in the communal lounge.</p> <p>There are external well-maintained gardens and seating available with shade for residents. There is a courtyard accessible from the dining room. There are ramps available at certain entry points to accommodate mobility scooters and ambulance transfer equipment.</p> <p>Handrails are installed in corridors, showers, and toilets to promote safe mobilisation. The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is appropriate and secure, bathroom floors are non-slip, and walking areas are not cluttered.</p> <p>The room sizes are adequate, and the lounges and dining areas are functional and comfortable for the residents.</p> <p>Maintenance is undertaken by both internal maintenance and external contractors. Clinical equipment is tested and calibrated by an approved provider at least annually or when required. The facility is being maintained in good repair.</p> <p>There is a centrally located nurses' station with a separate medication/treatment room.</p> <p>Interviews with residents and family members confirmed the environment was suitable and safe to meet their needs.</p> |
| Standard 1.4.3: Toilet, Shower, | FA | There are sufficient numbers of toilets and bathrooms for the number of residents. Privacy is maximised throughout with signs on all doors when occupied. All bathrooms and toilets are maintained to a good |

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| <p>And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | | <p>standard, are disability accessible with easy to clean walls and floors.</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>There is adequate space in the bedrooms and enough space for the safe manoeuvring of mobility equipment. Residents can personalise their rooms.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>There is adequate room for facilitating activities. Appropriate comfortable seating is provided, and quiet spaces are available for use. The main lounge in the rest home is large and is used for functions and activities. The dining rooms and lounges are within easy walking distances to bedrooms. Residents interviewed confirmed they use their rooms or external areas if they want privacy or quiet time. All furniture is safe and suitable for the resident group. The manager, residents and staff reported that refurbishments are continuing, and they enjoy the bright colours.</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>Support staff are responsible for laundry and cleaning services. There is a laundry with a clean and dirty flow. Personal clothing and linen are sorted and laundered on site. Towels and facecloths are done off site by an external contractor. Cleaning chemicals are securely stored in locked cupboards. Current safety material datasheets about each product are located with the chemicals in each area of service. The chemicals are stored appropriately. The cleaner's trolley is stored in a locked room when not in use. The residents and their families confirmed they were happy with laundry services. A visual inspection confirmed the laundry and cleaning processes are implemented.</p> |
| <p>Standard 1.4.7: Essential,</p> | PA Low | <p>There are emergency and disaster management plans in place to ensure health, civil defence and other</p> |

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| <p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | | <p>emergencies are included. The recent fire evacuation drill documentation was not available.</p> <p>An external contractor completed the required monthly fire checks. There are adequate supplies in the event of a civil defence emergency including sufficient food, water (water tank and bottled water), blankets and alternate gas cooking in kitchen and BBQ. A generator can be sourced locally if required.</p> <p>There are civil defence, sufficient personal protective equipment (PPE) supplies and first aid kits available. Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid is available at all times. The health and wellbeing manager/RN holds a current first aid certificate. There is a call bell system in place and there are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p> <p>There are emergency numbers and contractors' numbers documented for staff and this is available at the nurse's station. Staff complete security checks at night.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All bedrooms and communal areas are well ventilated and light. There are a mix of heating sources available. The maintenance person interviewed ensures the heating systems are running smoothly and that appropriate checks are performed. On the day of audit, the indoor temperature was comfortable.</p> <p>The residents and family interviewed, confirmed the internal temperatures and ventilation are comfortable during the summer and winter months.</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>Wakefield Homestead has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The health and wellbeing manager (RN) is the designated infection control person with support from all staff. Infection control matters are routinely discussed at all quality/staff meetings. Education has been provided for staff. The infection control programme has been reviewed annually. Visitors are reminded not to visit if they are feeling unwell. There is an electronic screening system in place at the entrance of the facility which reads visitors temperatures and reminds everyone to wear a mask. All visitors and contractors are required to sign in on entry to the facility, complete a wellness declaration, and use the hand sanitiser available in line with current Covid 19 restrictions. All contractors and suppliers are currently notifying the facility manager of staff vaccination status and are only providing staff who have been fully vaccinated. The service has recently lost two staff members under the current vaccination mandate.</p> |

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| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | <p>FA</p> | <p>There are adequate resources to implement the infection control programme. The health and well-being manager/RN is responsible for infection prevention and control. The infection control team is all staff through the quality/staff meeting. External resources including the infection control specialist at the DHB are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available</p> <p>The DHB held an onsite Covid 19 preparedness audit, the service is working alongside the DHB around staffing requirements and recommendations. Posters are located appropriately in the laundry and sluice areas around donning and doffing personal protective equipment. Adequate supplies of personal protective equipment (PPE) were sighted during the audit, and staff was knowledgeable around the appropriate use of PPE. Due to the facility running at full capacity, shared bathroom, and toilet facilities, if there were an outbreak, and the resident was unable to be isolated, the resident would need to be transferred to Nelson Hospital as discussed with the infection control specialist during the audit. The practice nurse at the GP practice located next door to the facility provide covid testing.</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> | <p>FA</p> | <p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two yearly and include Covid 19 policies and procedures.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | <p>FA</p> | <p>The staff orientation programme includes infection control education. The infection control coordinator has completed infection control updates and provides staff in-service education, which is now available through the online education platform. Education is provided to residents during daily support with all residents interviewed able to describe infection prevention practice including education for residents around Covid and keeping safe that is safe and suitable for the setting.</p> |

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| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and compared month by month. Outcomes and actions are discussed at quality/staff meetings and results posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. The infection rate is very low and there have been no outbreaks since the previous audit.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>Wakefield has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents using an enabler and one resident with a lap belt restraint. All restraint documentation and monitoring were in place. Staff receive training in restraint minimisation and challenging behaviour management. Staff complete restraint and challenging behaviour questionnaires.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | FA | <p>The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation is included in the restraint policy. The restraint coordinator is a RN and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA | <p>Assessments are undertaken by the restraint coordinator/RN in partnership with the resident and their family. Restraint assessments are based on information in the care plan, family, staff, and GP consultation and during observations. There is provision for emergency restraint if required, for safety of the residents, other residents/staff. Ongoing consultation with the family and staff is evident through multidisciplinary meetings and facility meetings. One restraint file (one lap belt) reviewed included</p> |

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| | | completed assessments that considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use Services use restraint safely | FA | The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation is included in the restraint policy. The restraint coordinator is a RN and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. |
| Standard 2.2.4: Evaluation Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur six-monthly as part of the multi-disciplinary review for the resident on restraint. Families are included as part of this review. A review one file of a resident using restraints identified that evaluations were up to date. |
| Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraints are discussed and reviewed at facility meetings. Meeting minutes include a review of the restraint and challenging behaviour education and training programme for staff. Staff receive orientation in restraint use on employment. |

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) |
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| <p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p> | PA Low | There are documented policies and procedures in place to guide management through employment stages. Interview questions and referee checks were evident in recently appointed staff files, however, not all individual employment agreements or job descriptions were able to be located either electronically or hard copy. | <p>Individual employment agreements could not be located for two of six staff files reviewed.</p> <p>Job descriptions could not be located for all six staff files reviewed.</p> | <p>Individual employment agreements could not be located for two of six staff files reviewed.</p> <p>Job descriptions could not be located for all six staff files reviewed.</p> |

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| | | | | 90 days |
| <p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p> | PA Low | <p>Questionnaires were completed recently by all staff around restraint, handwashing, infection control and fire safety. Manual handling, and medication competencies were current, and there were four members of staff booked on a first aid course, which will then have all staff with a current first aid certificate.</p> <p>During interview with staff, they described the orientation process, including receiving a pack with a checklist of policies to be read, and competencies to complete, and being 'buddied' with an experienced member of staff who signs off the checklist on completion of the task. This was evidenced in one staff file reviewed.</p> | Orientation checklists could not be located for three of six staff files reviewed | <p>Ensure a copy of the orientation checklist is included in the staff files.</p> <p>90 days</p> |
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | PA Low | <p>Wakefield Homestead has recently implemented an online education platform for staff to complete education. The health and wellbeing manager is currently setting up the library of education sessions to be completed. Education sessions have historically been included in staff meetings and have included sessions including advocacy, pain management, infection control, falls prevention, elder abuse and neglect, restraint, complaint management, and pressure injury prevention, however, not all compulsory education sessions have been completed in the last two years. There is a high number of attendance recorded at sessions which have been held at the staff meetings and using the online system.</p> | Education sessions yet to be held include sexuality and intimacy, code of rights including privacy and dignity, and chemical safety, these are planned to be included in the online library of sessions for staff to complete. | <p>Ensure all education sessions are held according to policy.</p> <p>90 days</p> |
| <p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p> | PA Moderate | <p>Staff completed a maintenance book. The maintenance person completes reactive maintenance and respond in a timely manner. External contractors are available to assist and support with maintenance issues. An annual preventative maintenance plan was not available.</p> <p>The boiler temperatures are recorded monthly however the hot water temperatures were last recorded in December 2020. An environmental audit was completed. Hot water temperatures at level on the day were 45</p> | <p>(i). No documented evidence of an annual preventative maintenance plan was available.</p> <p>(ii). Hot water temperatures were</p> | <p>(i). Ensure an annual preventative maintenance plan is available and completed.</p> |

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| | | degrees Celsius. | not documented as being monitored as required. | (ii). Ensure hot water temperatures are consistently monitored monthly. 90 days |
| Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Low | Most staff have a current first aid certificate on file, the remaining four (new staff) are booked on the next available course in early December 2021. Staff interviewed were knowledgeable around emergency management procedures and the use of fire cells within the building. The pre audit questionnaire stated the last fire drill occurred 2 November 2021 however, there was no documented evidence of the recent fire drill held. The last documented fire drill was completed was recorded on 17 July 2020. Staff interviewed confirm they completed annual fire evacuation training. Emergency and fire evacuation education is completed at orientation and annually. | There was no documented evidence that could be located to confirm that six monthly fire drills had been provided. | Ensure documented evidence of all fire drills are maintained. 90 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.