

Heritage Lifecare Limited - Te Wiremu House

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:	Heritage Lifecare Limited
Premises audited:	Te Wiremu House
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: 16 January 2018 End date: 17 January 2018
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:	73

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

Te Wiremu House Lifecare provides rest home, medical and geriatric hospital level care as well as dementia care for up to 94 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager. Residents and family/whanau spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, management, staff, a general practitioner and a nurse practitioner.

The audit has resulted in six continuous improvements in relation to recognition of Maori values and beliefs, quality management, service delivery and infection prevention and control. There are no areas requiring improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services and care provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. There was no evidence of abuse, neglect or discrimination.

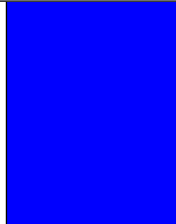
Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent and act on any advance directives.

Approximately half the residents identify as Maori. The model of care meets the needs met in a manner that respects their individual cultural values and beliefs and is a strength of the service. Residents of all cultures report high praise for how their individual values and beliefs are respected.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

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.		All standards applicable to this service fully attained with some standards exceeded.
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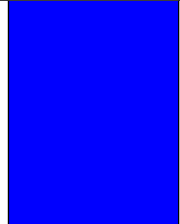
Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies any trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risk, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. 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.

Residents` information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant records are maintained in using an integrated record. Archived records can be retrieved if and when necessary.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Entry to the service is clearly defined in policies. If a potential resident is declined entry to the service, this is recorded and the referrer informed.

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring hospital, rest home and specialist dementia level care. This includes the needs of younger people. Staff are qualified to perform their roles and deliver all aspects of service delivery. The clinical services manager, team leader and registered nurses oversee the care and management of all residents, along with a team of staff. All residents are assessed on admission and assessment details

are retained in the individual resident's record. The multidisciplinary team and external health providers have input into the resident's care and support to promote continuity of care.

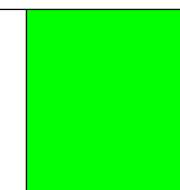
The residents' care plans document the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The service uses a mix of electronic and paper based assessment tools. The residents, and where appropriate the family/whanau, are involved in the care planning and review.

The activities available are appropriate for residents requiring hospital and rest home level care, including the needs of younger people under the age of 65.

The service has implemented a web based medication management system that complies with current legislation. Staff who assist in medication management are assessed as competent to perform their role. There is a process in place for residents to safely self-administer their medications.

The menu plans have been reviewed by a dietitian. Each resident is assessed on admission for any identified needs in relation to nutritional status, weight, likes, dislikes and cultural needs. The kitchen has a registered food safety plan, with annual inspections, that complies with current food safety legislation and guidelines.

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.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and products used are evaluated for effectiveness.

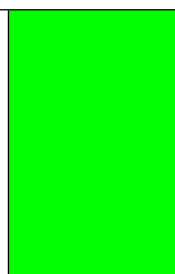
Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported timely staff response to call bells. Security is maintained.

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.
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The organisation has implemented policies and procedures that support minimisation of restraint. Two enablers and nine restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually. Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff. The GP, or other specialised input, is sought as required.

Infection control education is provided by the infection control coordinator or external specialists, who have current knowledge of best practice. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	48	0	0	0	0	0
Criteria	6	95	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the in-service and online education programmes. Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents reported that they understand their rights. The family/whānau reported that residents are treated with respect and dignity.</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>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of</p>

		<p>attorney (EPOA) and ensuring, where applicable, this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. An advance directive and advance care plan are used to enable residents to choose and make decisions related to end of life care. The files reviewed had signed advance care plans that identify residents' wishes and meet legislative requirements</p> <p>Residents and family/whānau (where appropriate) are included in care decisions.</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>Advocacy information is available in brochure format at the entrance to the facility. Residents and family/whānau are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The staff interviewed reported knowledge of residents' rights and advocacy services.</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 reported they are supported to be able to remain in contact with the community through outings and walks. Policy includes procedures to be undertaken to assist residents to access community services and a mobility van is available. The activities programme involves linking with other aged care providers and support services for the younger residents.</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/compliments 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 knew how to do so.</p> <p>The complaints/compliments register showed that three complaints had been received since the previous audit and that action was taken, through to an agreed solution, are documented and completed within the required timeframes. Action plans showed any required follow up and</p>

		improvements have been made where possible. Each complaint was signed off by the facility manager and dated. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Copy of the Code and other information related to rights are in the residents' rooms and displayed throughout the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families, as confirmed by interview with the clinical staff. Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Residents and family/whanau report that the residents are addressed in a respectful manner that upholds their rights.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of resident related information. The service has several younger people and their independence and links with the age appropriate community resources is encouraged. The residents interviewed and files reviewed evidenced that the individual values and beliefs of the residents are respected. There were no concerns expressed by the residents and family/whānau about abuse or neglect. Staff interviewed report knowledge of residents' rights and understand dignity, respect and what to do if they suspected the resident was at risk of abuse or neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability	FA	The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents is a strength of the service. A commitment to the Treaty of Waitangi and a

<p>needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>family/whānau approach is included. Whānau input and involvement in service delivery and decision making is sought if applicable. The in-service education programme includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whanau. The staff and whānau interviewed reported that there are no known barriers to Maori accessing the services.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The cultural and/or spiritual needs of the resident are provided for in consultation with the resident and family as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff, to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Residents reported that their individual cultural, values and beliefs are met. Staff confirmed the need to respect the individual culture, values and beliefs of residents.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family/whanau reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. 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>
<p>Standard 1.1.8: Good Practice</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>professionals. The service has access and support from visiting specialist nurses, palliative services and mental health teams. The general practitioner (GP) or nurse practitioner (NP) visits the service at least weekly. The NP reports that the service excels at picking up early warning signs of deterioration, to act promptly on health issues before they reach a crisis point (refer to 1.3.3.4). Residents' and family/whānau' satisfaction surveys evidenced overall satisfaction with the quality of the care and services provided.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included quality projects into pressure injury management.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents able to communicate effectively in English, staff being able to provide interpretation and many are able to speak in te reo Maori as and when needed and use of family members and volunteers, when appropriate. There are communication strategies in place for residents with cognitive impairment or who have non-verbal means of communication.</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>	<p>CI</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents reviewed described longer term objectives and the associated operational plans. A sample of weekly and monthly reports to the support office/management showed the information required was reported as requested and was followed up by the national quality</p>

		<p>manager and quality team.</p> <p>The service is managed by a facility manager who holds relevant management qualifications and has been in the role for 10 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency by attending related business courses and the organisation's annual conference for facility managers which was attended in November 2017.</p> <p>The service holds contracts with Tairāwhiti DHB for up to 94 residents. Respite care (Nil residents on the day of the audit), YPD (Nil residents), rest home (23), dementia (20), hospital geriatric and medical, hospital psychogeriatric level care (30) and palliative care. Two palliative care residents were included with the hospital geriatric and medical level residents.</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>When the facility manager is absent, the clinical services manager carries out all the required duties under the delegated authority with support from the regional operations manager and support office personnel. During absences of key clinical staff, the clinical management is overseen by one of the senior registered nurses who is experienced in the sector and is able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</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>Heritage Lifecare Limited has reviewed and implemented Heritage Lifecare policies and procedures since the previous audit. Any new and/or draft policies requiring consultation are sent out to facilities for staff to make any changes or have input as needed. All legislative requirements are effectively met. Any obsolete documents are able to be stored appropriately in a locked room. An archive system is utilised and records can be retrieved as needed.</p> <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement and is understood by staff. This includes the management of incidents and complaints, audit</p>

		<p>activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infection and restraint minimisation and safe practice. This is a strength of the service.</p> <p>Terms of reference and meeting minutes reviewed confirmed more than adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of key quality indicators occurs and related information is reported and discussed at the quality/infection control/restraint/staff meetings. Minutes of meetings reviewed include discussion on pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results and activities. Staff reported their involvement in quality and risk management activities through the internal audit activities that they are involved in where possible. The clinical services manager collates all data and this is reported firstly to the facility manager and then onto the support office as required. Relevant corrective actions are developed and implemented to address any shortfall and demonstrated a continuous process of quality improvement is occurring. Resident and family surveys are completed in June annually. The outcome of the 2017 survey provided positive comments for all staff and management.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported on the electronic incident management system now implemented (GOSH), and management can access this information anytime.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one infection outbreak (November 2017) notified to public health since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>FA</p>	<p>Human resources management policies and procedures are based on good employment practice and relevant legislation. The recruitment</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>process includes reference checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A 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 orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. 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 TDHB. The clinical services manager is the education coordinator and the Careerforce assessor for the service. The clinical services manager stated that all new staff complete the dementia series before working in the dementia service and are buddied with another care giver until they feel confident. All caregivers have level 3 status. Not all care givers are first aid trained. All staff currently working in the dementia care service have completed all required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There 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). The policy states that staffing levels reflect the number of residents, acuity of residents, residents' care levels, and the layout of the facility. The clinical service manager adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family/whanau interviewed supported this. Observations and review of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty</p>

		has a current first aid certificate and there is 24/7 registered nurse coverage at all times.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was completed in the residents' files sampled for review. Clinical notes were current and integrated with GP, NP and allied health service provider notes. This includes interRAI assessment information entered into the electronic database. Recent records sampled were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public 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 identified.</p>	FA	<p>The admission policy includes the procedure to be followed when a resident is admitted to the home. The admission agreement contains all required information and is based on an aged care association agreement. Entry screening processes are documented and communicated to the resident and their family/whānau to ensure the service can meet the needs of the resident. The residents and family/whānau reported the admission agreement was discussed with them prior to admission and all aspects were understood. Needs assessments from various funders (eg, DHB, ACC) for either rest home, hospital or dementia level of care were sighted in the resident's files sampled.</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>All residents' exit, discharge or transfer is documented using specific forms. The service utilises the transfer forms approved by the DHB and this was confirmed in files reviewed. Known risks are identified to the place of transfer to manage the residents safely. Expressed concerns of the resident and family/whānau are clearly documented including advance directives and EPOA documentation. This was confirmed in residents' files reviewed.</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 policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management, using an electronic system, was observed on the days 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. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>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.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>The medications are prescribed through the web based system for good electronic prescribing practices, which includes the live update of any changed medications, the 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 record. Standing orders are not usually required due to the live updating of the medication record, however, the service does have standing order guidelines that were current and comply with legislation.</p> <p>There were two residents in the rest home who self-administer medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for analysis of any medication errors, with quality projects and internal audits evidencing the reduction in medication errors since the introduction of the web based medication</p>

		management system.
<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>Policies and procedures implemented cover all aspects of food preparation. Documentation identifies that safe food hygiene management practices are followed.</p> <p>The menu has been reviewed by a registered dietitian as being suitable for the residents living in a long-term care facility. The kitchen has dietary information for all residents and their likes and dislikes are catered for. Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these met. The residents and family/whānau reported being overall satisfied with the meals and fluids provided, including catering for their individual preferences.</p> <p>Food, fridge and freezer recordings are undertaken daily and meet requirements. The service has a registered food safety plan and has an annual external audit on the food management systems. Any non-conformances from the external review have been actioned.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local Needs Assessment and Service Coordination NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Management reported that they refer residents to different levels/types of care if they are unable to support the resident (such as hospital psychogeriatric level).</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	FA	<p>The initial assessment, which includes assessment of the residents' health and personal care needs, is completed on the day of admission.</p>

gathered and recorded in a timely manner.		Registered nurses utilise standardised risk assessment tools for the initial and ongoing assessments. The interRAI, along with other paper based assessments, information gained from the resident and their family/whanau, referral information, observations and examinations carried out are used as a basis for developing the long-term care plan. There were specific assessment tools and management plans for behaviours that challenge and end of life care. The residents and family/whānau expressed satisfaction with the support provided and confirmed their involvement in the assessment process.
<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>In all files sampled, evidence was sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these included falls risk, pressure area risk and pain management. The assessment outcomes from the interRAI assessment process were included to update the care plan. The care plans are discussed with the clinical team at handover. The files sampled of residents living in the dementia unit have a management plans for diversional activities over the 24-hour period.</p> <p>All health professionals documented in the resident's individual clinical file and have access to care plans and progress notes as part of the integrated file system. Documentation in files reviewed included nursing notes, medical reviews and hospital correspondence. The residents reported that they are included in the care planning and are aware of any changes and these are discussed with them. Care staff reported they are informed of any changes to care plans at shift changeover. The residents reported satisfaction with the care provided.</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	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP and NP interviewed, verified that medical and nursing input is sought in a timely manner, that orders are followed, and care is of a high standard.

		Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
<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>	CI	Te Wiremu House Lifecare has a family/whanau philosophy for the activities programme that is based on meaningful activities and family/whanau and community involvement. The diversional therapists plan activities to meet the resident's abilities, this includes the needs of the younger people at the service. The activities programme has gained a continuous improvement rating.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluations are conducted at least six monthly and recorded on the care plan. The service has processes in place to use the built-in evaluation scores when the service reassesses the resident using the interRAI assessment, and records this on their own paper based evaluation record. Care evaluations are conducted for all the residents' needs and recorded how the resident's goals have been met over the past three months.</p> <p>When there are changes in the resident's needs, the service changes the long-term care plan to capture this. The long-term care plans identify the need, interventions and evaluation of the interventions. There are also additional short-term plans, such as wound treatment, falls and falls minimisation plans, which capture any short-term changes. Wounds are evaluated at each dressing change and at least weekly by the clinical team. If the issue then becomes a long-term need, these are then recorded and updated on the long-term care plan. Any changes to care plans are reviewed by the clinical team (nurses, caregivers, physiotherapist) at handover.</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</p>	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to radiology, health screening, and medical/surgical specialists. There are several specialists/health providers that also conduct visits to Te Wiremu, such as audiologists, podiatrists and dietitians. 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 sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>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 they also provided relevant education/training for staff. Material data sheets and product information were available where chemicals were stored and utilised. Staff interviewed knew what to do should any chemical spill/event occur. A spill kit was available and accessible if needed.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness dated expiry 06 July 2018 was sighted, framed and displayed at the entrance to the facility.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with two maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are</p>

		appropriately actioned and that they are pleased with the environment.
<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	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. There is one wing of 11 individual rooms (mostly hospital residents in this wing) that all have their own ensuite bathrooms with a shower, vanity unit and toilet. All other residents' rooms in the facility are in close proximity to the toilets and showers available in each wing. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. There are separate toilets allocated for staff and visitor use. Signage is available.
<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	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation except for one designated double room in the rest home wing. This room has one resident in it so is currently used for single accommodation. Rooms are personalised with furnishings, photos, paintings and other personal effects displayed to promote a homely atmosphere. There is adequate room to store mobility aids, wheel chairs, hoists and mobility scooters. Staff and residents reported the adequacy of bedrooms.
<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	Communal areas are available for residents to engage in activities. There are separate lounges in each wing and an additional lounge area/sunroom is available for residents to engage in activities. There is a separate whanau room in Kauri Wing, which was being utilised by whanau during the audit. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture sighted is comfortable, appropriate to the setting and meets the residents' needs.
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	Laundry is undertaken onsite in a dedicated laundry. Laundry staff

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>interviewed demonstrated a sound knowledge of the laundry processes, dirty clean flow and handling of soiled linen. Personal protective equipment was readily available. The laundry has a sluice facility and washing machines and driers are commercial standard which are regularly checked and maintained by a contracted service provider and overseen by maintenance personal. All material data sheets and product information are accessible in the laundry. Residents/families interviewed reported the laundry is managed effectively and personal clothes are returned in a timely manner.</p> <p>There is a designated cleaning team (who are trained to cover the laundry service as well) who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. The cleaners` trollies were stored safely in a locked room when not in use.</p> <p>Both cleaning and laundry processes are monitored by the contracted service provider and through the organisation`s internal audit programme on a regular basis.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and Civil Defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The facility is closely linked with the Tairāwhiti District Health Board`s (TDHB) emergency plan. The current fire evacuation plan was approved by the New Zealand Fire Service 30 May 2016. A trial evacuation drill took place last on the 09 August 2017. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water tanks (2 tanks on site), blankets, mobile phones, torches, batteries and a gas barbeque and other resources are available and are regularly checked with the checklist developed and implemented. A contractor will provide a generator in the event of an emergency. Emergency lighting is tested regularly.</p> <p>A nurse call bell system is available for residents to use if requiring</p>

		<p>assistance. Call bell audits are completed and residents and families interviewed reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the alarm is activated by the care staff. Staff recheck on their respective shifts when checking residents.</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. Rooms all have natural light and opening external windows. There are areas opening onto small courtyards and a ramp is available from the sunroom to access the garden. Heating is provided by two boilers. There are gas heaters in residents` rooms and in the hallways. Electric heat pumps/air conditioning units were sighted in the laundry, kitchen, glassed in sunroom/lounge and in the dementia wing. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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>There are designated infection control coordinator and infection control person for the facility. They have a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meetings and the combined infection control/quality/safety committee meetings. The infection committee receives the monthly quality, risk and infection control issues. The last review of the infection control programme was conducted in April 2017. The review included the effectiveness of the infection control programme, education, surveillance and equipment.</p> <p>There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise family/whānau not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. Staff demonstrated good knowledge and application of infection prevention and control principles.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinators implement the infection control programme, with support from all staff. There is also an external contract with the DHB infection control specialist to assist in the development of policies and review of the infection control programme. Infection control matters are discussed at the monthly staff meeting. If the infection control coordinators require additional advice or support regarding infection prevention and control they can access this through the DHB or GP.</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 infection control policies and procedures have been developed by the organisation and reflect current accepted good practice. The service has access to good practice resources from an infection prevention specialist. The policies are appropriate to the services offered by the facility and reviewed by the head office.</p> <p>Staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions per the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.</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>The infection control coordinators and external specialists conduct most of the face to face infection control education. There are online learning modules that are part of the mandatory education programme on infection prevention and control. The infection control coordinator interviewed demonstrated current knowledge in infection prevention and control. They have attended ongoing education on current good practice in infection prevention and control.</p> <p>As required, infection control education can be conducted informally with residents, such as reinforcement of infection control practices with washing hands, blowing noses, cough etiquette and personal hygiene when assisting with toileting.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>The service uses standardised definitions applicable to aged care that</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>are provided by the external benchmarking service to identify infections. The type of surveillance undertaken is appropriate to the aged care service with data collected on urinary tract infections, influenza, skin infections and respiratory tract infections. There is monthly collection and collation of the types and numbers of infections in both the rest home, dementia and hospital services.</p> <p>The data and reporting of the statistics and analysis is provided to the organisational wide governance/quality team. The outcomes are fed back to the staff at the next staff meeting. The service has implemented a quality project to reduce the number of urinary tract infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 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 the role and responsibilities. On the day of the audit, nine residents were using restraints (two residents had been approved two types of restraints to be used) and two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, made up of the restraint coordinator, a registered nurse and the general practitioner (GP), are responsible for the approval of the use of restraints and the restraint process. It was evident from review of restraint approval group meeting minutes, residents` files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whanau/EPOA involvement in the decision making</p>

		was on record in each case. Use of a restraint or an enabler is part of the lifestyle care plan.
<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 for the use of restraint were documented and included all requirements of the Standard. The registered nurse undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whanau/EPOA. The restraint coordinator described the documented process. Families interviewed confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised and the restraint coordinator described how the alternatives to restraints are discussed with staff, family/whanau (eg, the use of sensor mats and/or low beds). When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details required. Restraint alert stickers are available for use in the lifestyle care plan and for the clinical records. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected at all times.</p> <p>A restraint register sighted is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have all received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to clearly understand that the use of restraint is to be minimised and how to maintain safety when in use.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents` records showed that the individual use of restraints is reviewed and evaluated during lifestyle care plan and interRAI reviews, at six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedures was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a six monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of each restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the doctor, nurse practitioner, staff and families.</p> <p>A six monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with staff, the restraint coordinator and GP confirmed that the use of restraints is minimised.</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
<p>Criterion 1.1.4.3</p> <p>The organisation plans to ensure Māori receive services commensurate with their needs.</p>	CI	<p>Te Wiremu House has approximately 50% of resident who identify as Maori and approximately 65% of staff who identify as Maori. The resident and family/whanau report that they are ‘highly satisfied’ with the way that the staff provide culturally appropriate care and support. The design, decoration and daily living activities inside and outside the home are tailored to create a familiar and culturally appropriate environment for all residents and family/whānau. The residents are encouraged with their independence and participation in activities that they have normally participated in. Te Wiremu House provides provisions for special foods, cultural activities, spiritual services in te reo Maori, bi-lingual language services, karakia, war veteran support, whanau rooms, follow hapu and noa, recognising taonga, kaumatua programme</p>	<p>The achievement of implementing support and services to meet the needs of residents who identify as Maori is rated beyond the expected full attainment. The service’s approach and philosophy in provision of culturally appropriate care is gaining positive results in the reduction of challenging behaviours and recognising the importance of whanau in the resident’s care. With the culturally appropriate model of care and philosophy implemented at the service, improvements in individual resident reduction in challenging behaviours and increased connection with whānau and marae has resulted. Positive outcomes have been measured through staff, resident and family/whānau satisfaction surveys.</p>

		and linkage with the Turanga Health, Maori Kawa. Over the past 10 years the service has increased the number of staff who identify as Maori and an education and support programme to instil that it 'is OK to be Maori' in the workplace. The data from 2008 to 2017 evidences an increase in Maori residents from minimal in 2008 to 50% in 2017. With the proactive approach taken, growing trust within the community and communication with residents and whānau, residents and whānau choose to stay for their end of life support. The whānau and staff also reported increases in resident happiness and self-worth, with the residents participating in activities that they have previously enjoyed, such as visiting mokapuna, kaumatua support and culturally appropriate food	
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>The purpose, values, scope, direction and goals of the organisation Heritage Lifecare Limited (HLL) are clearly identified and are reviewed annually at support office. All services receive a copy of the Quality and Risk Management Plan which is available electronically and this was available for review. The plan for 2017 - 2019 sighted evidenced that the plan was to be reviewed regularly to ensure objectives were able to be efficiently and effectively met. The facility manager explained the review process and her role in the organisation. The purpose, values and scope was documented in all service brochures, and in the resident information pack sighted. This was provided to prospective residents/families and those admitted to the service.</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate that the facility manager and the clinical services manager have in addition to adhering to the organisation's objectives have collaboratively developed and implemented site specific objectives and strategies to improve services for the residents. Each strategy identified has a descriptive plan of action on how these objectives can be effectively met and who is responsible. The 2017 objectives reviewed provided evidence of improvements made in relation to resident safety and the 2017 resident/family surveys provided excellent feedback about the service. Satisfaction was acknowledged from both residents and families regarding all aspects of service provision and the smoothness of the transition of change of organisation was appreciated. This was completed is in addition to information that is</p>

			<p>required to be reported through to support office. A full narrative report is also sent through to support office to verify outcomes and progress on a regular basis. The facility manager provides a comprehensive narrative report to support office monthly as well as the required weekly reporting. The facility manager explained that the service aims and strives to ensure the residents receive holistic focused care and that all expectations can be achieved to make this facility one of the `best` aged care residential care facilities in the region, taking into consideration the cultural basis of service provision which is significantly a Maori health provider.</p>
<p>Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	<p>CI</p>	<p>The facility manager and the clinical services manager interviewed clearly understood the organisation`s quality and risk management system. Staff are involved in the internal auditing system at the required timeframes allocated on the audit schedule developed and implemented. The registered nurses and the clinical services manager are responsible for recording the required clinical indicator information monthly. This information is later formally collated by the clinical services manager who in consultation with the facility manager report the clinical information and non-clinical information directly to the HHL support office on a weekly and monthly basis. In addition, all relevant information is reported in a narrative form by the facility manager to explain outcomes and progress attained. Any quality improvements or outcomes requiring further improvement or action are also included in the information provided to support office.</p>	<p>Having fully attained the criterion, the service can in addition clearly demonstrate an ongoing review and analysis process and corrective actions are documented from the information gathered. In addition to the required clinical and non-clinical reporting obligations to HLL support office, a sample of the narrative reports were reviewed which were extensively comprehensive and provided clearly defined outcomes of quality improvements which have in one way or another totally benefited the residents significantly. The site objectives set when the site strategic plan was developed for Te Wiremu House Lifecare in 2017 were all effectively met. With a collaborative team approach and involvement of all staff this enabled the goals to be achieved. The national quality manager for HLL was present at the audit and commented and endorsed the finding that the reports reviewed were the most comprehensively detailed reports provided by a facility manager across all current</p>

			service facilities. The comprehensive content of the report clearly described and demonstrated how minimal changes made, for example, in regard to staffing allocation, staff retention and continued recognition of staff whether working in clinical or non-clinical areas of service delivery was beneficial for the individual residents in respect of safety and care delivery.
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	CI	<p>Te Wiremu House Lifecare has access to a multidisciplinary team for the provision of care and supports to residents. The service is involved in a nurse practitioner programme and has a nurse practitioner available for consultation. Both the nurse practitioner and visiting hospice staff report that the staff at Te Wiremu House Lifecare provide an 'outstanding' quality of care and support the residents and their family/whānau. The quality data records that there has been a decrease in admissions to the acute care hospital and a decrease in the use of antimicrobials with the early access to consultation from health professional, such as the GP, NP and hospice services. The service has been successful in achieving outcomes in terms of increasing the level of confidence and ability for the staff to deliver palliative care and identify the early warning signs of deterioration. Feedback is documented as very positive from residents and family/whānau who report high satisfaction with the team approach to care and supports provided at Te Wiremu House Lifecare.</p>	<p>The achievement of the initiative related to communication of early signs of deterioration to the nurse practitioner or general practitioner is rated beyond the expected full attainment. The quality improvement data records that with the timely access to either the NP or GP there has reduced admissions to the acute care hospital and reduced use of antimicrobials. The quality data sighted has a documented review process which includes analysis and reporting of findings to the national support office, management and staff. The NP reports that the communication of early warning signs of deterioration is one of the strengths of the service. The quality data evidences action taken based on findings and improvement to service provision. The residents and family/whānau interviewed report high satisfaction with the quality of care that the team provide at Te Wiremu House Lifecare.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and</p>	CI	<p>There is a full range of social activities that are available on the weekly programme for all</p>	<p>The achievement of the quality improvement projects in activities programmes and</p>

<p>provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>residents to participate in. The service has conducted several quality improvements in activities related to the use of sensory 'busy board' and for the activities for the younger residents. Each of the quality improvement projects have include aims and objectives, the goals that were trying to be achieve and an evaluation. The evaluations also include feedback from the residents, all of which are evidencing positive outcomes and increased enjoyment.</p>	<p>implementation of programmes for younger residents and activities related to reducing challenging behaviours is rated beyond the expected full attainment. With these projects there has been a documented review process which includes the analysis and reporting of findings. The introducing of new club activities and the evaluation of existing clubs includes documenting actions to make improvements in the activities programme. There has been increased staff knowledge, confidence and skill in resident self-worth and developing and increasing resident's skills and participation in meaningful activities. Positive outcomes have been measured in staff, resident and relative satisfaction.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>A quality initiative project was conducted on urinary tract infections (UTIs) from December 2016 to July 2017. This included the analysis of suspected infections against those that were confirmed as infections using standardised definitions. The outcomes of the quality initiative have been reported through the quality system and support office quality and governance team meetings. Training and consultation with specialists and the nurse practitioner has led to critical thinking and clinical reflection around identification of infections, urinary specimen collection and early non-pharmacological actions. The data analysis highlighted a decrease in suspected UTIs and reduction in urinary tract infections. The quality initiative records that the goals of the project have been met, evaluation has been completed and reported to the clinical governance team and staff.</p>	<p>The achievement of the infection prevention and control project related to reducing infections is rated beyond the expected full attainment. The infection prevention and control team have conducted a project on UTI and reduction of antimicrobial usage. The quality improvement projects sighted have a documented review process which includes analysis and reporting of findings to management and staff. The projects documentation provides evidence of action taken based on findings and improvement to service provision, with the reduction of UTIs. Resident safety been measured because through the review process, which evidences positive outcomes in reducing infections and increasing resident's wellbeing.</p>

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End of the report.