

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

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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:	Te Aroha & District Health Services Charitable Trust
Premises audited:	Te Aroha & District Community Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 May 2018 End date: 8 May 2018
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	39



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Te Aroha and District Community Hospital is governed by a community trust board. The service provides rest home and hospital level care (geriatric and medical) for up to 43 residents. On the day of the audit there were 39 residents. The residents, relatives and general practitioner interviewed commented positively on the care and services provided at Te Aroha.

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

The facility manager has been in her role since November 2017, and was clinical manager for the service prior to this role. She has experience in health managerial roles prior to working at Te Aroha.

Improvements are required around; full implementation of quality processes, restraint monitoring, documentation of care plan interventions, and medication documentation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Care at Te Aroha is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural needs are met. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The quality and risk management programme includes service philosophy, goals and a quality/business planner. Meetings are held to discuss quality and risk management processes. Residents'/family meetings are held regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. Falls prevention strategies are in place that includes the analysis of falls incidents. An education and training programme has been implemented with a current training plan in place for 2018. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior health care assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals and baking provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are sufficient individual and communal showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

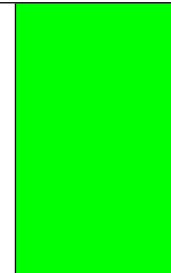
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. There were four residents with restraint and four residents with an enabler. Restraint management processes are in place.

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.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	46	0	2	2	0	0
Criteria	0	96	0	3	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with eight care staff (three caregivers, three registered nurses (RN), one enrolled nurse (EN) and one diversional therapist) confirmed their familiarity with the Code. Interviews with six residents (three rest home and three hospital) and six families (one rest home and five hospital) confirmed that services are being provided are in line with the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has in place a policy for informed consent. Completed resuscitation consent forms were evident on all resident files reviewed (four rest home including one respite and one general practitioner (GP) referral and three hospital including one primary acute convalescent care (PACC)). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed in the residents' files.
Standard 1.1.11: Advocacy And Support	FA	A policy describes access to advocacy services. Staff receive training on advocacy as part of the set training programme. Information about accessing advocacy services information is

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents and relatives interviewed confirmed that relative/family visiting could occur at any time.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a documented complaints policy and complaint forms are freely available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. There is a complaints' register. Verbal and written complaints are documented. Three complaints were made in 2017 and no complaints received in 2018 year-to-date. Complaints for 2017 included one through the DHB which has been resolved with no further action needed by the service. Two other complaints have comprehensive action plans documented with evidence of follow-up and communication with the complainants. One health and disability complaint for 2016 around pain management was fully resolved. All staff interviewed were able to describe the process around reporting complaints.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service can provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the information pack is discussed with the resident and the family/whānau. The information pack includes a copy of the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and	FA	The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. There is a policy that

receive services in a manner that has regard for their dignity, privacy, and independence.		describes spiritual care. All residents interviewed indicated that resident's spiritual needs are being met when required. Staff receive training on abuse and neglect, last occurring in October 2017.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. There was one resident who identified as Māori at the time of the audit. The facility manager identifies as Māori and is a recognised Kaumātua. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review as demonstrated in the resident files sampled. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment, including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural safety/awareness.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	The facility has a staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had an understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include the requirement to attend orientation and ongoing in-service training.</p> <p>The service has embarked on significant environmental upgrades as a result of internal service</p>

		<p>reviews. This has included re-painting, new carpets, five rooms upgraded, a new hoist and hospital bed, upgraded kitchen, a review of and changed cleaning schedule and a new, very large television.</p> <p>Relatives and the GP commented on the service and clinical improvements with the new clinical leadership.</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 stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen incident/accidents forms reviewed had documented evidence of family notification or noted if family did not wish to be informed.</p> <p>Relatives interviewed confirmed that they are notified of any changes in their family member's health status. A residents'/relatives meeting occurs monthly. Any issues raised from these meetings are followed up by the facility manager. Interpreter services are available as required.</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>A community trust board governs Te Aroha and District Community Hospital. The service provides rest home and hospital level care (geriatric and medical) for up to 43 residents. On the day of the audit, there were 39 residents. There were 22 rest home level residents (15 in the rest home and 7 rest home in the hospital) including one respite resident and one GP admission contract and 17 hospital level residents including two under the post-acute convalescing care contract (PACC). All other residents are under the Age-related residential care services agreement.</p> <p>A 2016 - 2019 quality and risk management plan is in place. This plan includes the vision, mission and values of the organisation. Strategic goals and objectives are documented and have an annual review. The staff report that the board are very supportive.</p> <p>The facility manager (RN) has been in her role since November 2017 full-time, and was clinical manager for the service prior to this role. She has experience in managerial roles prior to working at Te Aroha. The facility manager has undertaken a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months. She is supported in her role by a clinical operations administrator (enrolled nurse).</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the temporary absence of the facility manager, the clinical operations administrator and a senior RN take on the role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>There is a business/strategic plan that includes quality goals and risk management plans for Te Aroha. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The facility manager advised that she is responsible for providing oversight of the quality programme on-site. A monthly report is also provided to the board, including both business and clinical quality data.</p> <p>There is a quality and risk management programme in place that is designed to monitor contractual and standards compliance. Data is collected in relation to a variety of quality activities. The internal audit programme has not always been completed as scheduled and not all issues identified had corrective action plans and resolutions. A survey has recently been completed.</p> <p>Since undertaking the overall facility manager's role, the manager has reviewed services and documented an action plan. As a result, a number of improvements have been made to the environment. The action plan is reviewed monthly.</p> <p>The service has a health and safety management system that is regularly reviewed. The health and safety meeting includes three nominated board members. Restraint and enabler use (when used) is reported within the management and registered nurse meetings. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>There is an implemented annual staff training programme based around policies and procedures. Records of staff attendances are maintained. The infection control programme is implemented, and all infections are documented monthly.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The facility manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Incident forms reviewed demonstrated that appropriate clinical</p>

<p>the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>follow-up and investigation has occurred following incidents. Discussions with the staff confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</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>	<p>FA</p>	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications and experience. A copy of practising certificates is kept. Eight staff files were reviewed (three RNs, three healthcare assistants, one diversional therapist and one activities assistant) identified that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. Completed orientations were on file and staff interviewed described the orientation programme provided. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. The RNs are able to attend external training, including sessions provided by the district health board (DHB). Discussions with the healthcare assistants and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. There are seven RNs, five have completed interRAI training and two are in the process of completing.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There are policies in place to determine staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager (RN) is on duty Monday to Friday and is available on call weekends and after hours. The clinical operations administrator is on duty Monday to Friday. There is a RN on duty 24-hours a day with additional hours provided for interRAI and care planning.</p> <p>The health care assistant (HCA) rosters are as follows;</p> <p>For the rest home wing (15 rest home residents), there is one long shift and one short shift for the AM and for the PM and one HCA at night.</p> <p>For the hospital wing (17 hospital, 7 rest home residents), there is two long shifts and two short shifts for the AM, there are two long shifts and one short shift for the PM and one HCA on nights.</p> <p>Residents and relatives stated there were adequate staff on duty at all times. Staff stated they</p>

		feel supported by the RN, and facility manager who responds quickly to after-hour calls.
<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	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregiver or RN.
<p>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	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. All three admission agreements for permanent residents sighted were signed and dated.
<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	Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. Respite and GP referral residents have their discharge recorded in the progress notes.
<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>	PA Moderate	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit and all requirements had been met. There are standing orders in use and these meet the required standards.</p> <p>The facility uses an electronic system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent HCAs administer medications. All RNs have syringe driver training completed by the hospice. The medication fridge temperature is checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications electronically. The medication charts/records were reviewed for 14 hospital/rest home residents (including one respite, one GP referral and one PACC resident). Medications are reviewed at least three monthly by the GP. There was</p>

		photo identification and allergy status recorded. 'As required' medications did not always have 'indications for use' documented. The respite resident did not have a medication chart.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service has two cooks and one relief cook who work 5.30 am to 2.00 pm and are rostered to cover the week. There are two kitchenhands and one on call who between them work 6.30 am to 2.00 pm and 4.00 pm to 7.00 pm and are rostered to cover the week. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen.</p> <p>There is a well-equipped kitchen and all meals are cooked on-site. Meals are transported to the dining rooms by bain maries or hot boxes. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. Evening meals are reheated by the kitchenhands and food temperatures are checked.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by a dietitian. The cooks have noted that the Indian resident does not eat beef. All residents and family members interviewed were satisfied with the meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>assessments had been completed for all long-term resident files reviewed. Overall, the goals were identified through the assessment process and linked to care plan interventions (link 1.3.5.2). Other assessment tools in use included (but not limited to) falls risk, pressure injury, pain and depression.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. However, shortfalls were identified around care plan interventions. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process and reviews. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, physiotherapist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status and family members confirmed this. Four out of seven care plans sampled had interventions documented to meet the needs of the resident (link 1.3.5.2). Care plans have been updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently five wounds being managed. One chronic wound has had input from the GP and wound care nurse specialist. The RNs stated that they have access to the WDHB wound care nurse specialist whenever required. There are currently no pressure injuries.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one diversional therapist who works 32.5 hours a week Monday to Friday. There is an activities assistant who works 35 hours a week Monday to Friday. The activities assistant is currently completing the diversional therapy course. On the days of audit residents were observed playing cards, snakes and ladders, listening to music, listening to a newspaper reading and doing exercises.</p> <p>There is a weekly programme in large print on noticeboards in communal areas. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music, craft and, walks outside.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are weekly interdenominational church services held in the facility and Catholic and Anglican Church members come in to give communion. There are van outings at least weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated.</p> <p>The facility has a cat and a pet therapy team visit fortnightly.</p> <p>There is community input from pre-schools, schools, the Red Cross and the RSA. On the second Monday of each month there is a group of residents who go out to the RSA fellowship group.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly. Resident meetings are held monthly. The activities team also put out a survey for feedback.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The three long-term care plans of permanent residents that were reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem (link 1.3.5.2). Activities plans are in place for each of the long-term residents, and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist and mental health services for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness which expires 8 September 2018. There is a maintenance person on-site for 20 to 25 hours a week. Contractors are used when required.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms are carpeted, and communal showers and toilets have nonslip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained by contractors. There are extensive outdoor areas, and many have seating and shade. There is safe access to all communal areas.</p> <p>Health care assistants interviewed stated they have adequate equipment to safely deliver cares for rest home and hospital level of care residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And</p>	FA	<p>Every room except the four-bed ward has a hand basin. There are three rooms with ensuites otherwise all rooms share communal showers and toilets. Fixtures, fittings and flooring are</p>

<p>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>appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and in the hospital a hoist or shower trolley, if appropriate. There are privacy signs on all shower/toilet doors.</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>All resident's rooms are single except for one four-bed ward. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. The 28 dual-purpose rooms are spacious enough to manoeuvre a hoist for transfers. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large communal areas where activities occur. There are also smaller areas with clusters of chairs and coffee tables where residents who prefer quieter activities or visitors may sit. There are spacious dining rooms.</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>Personal laundry is done on-site by health care assistants. All other laundry is contracted out. The laundry is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away. All chemicals on the cleaner's trolley were labelled. There is a sluice room for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept closed when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food and supplies (torches, radio and batteries), emergency power and barbeque. A generator would be hired if required.</p> <p>There is an approved and current fire evacuation scheme in place. There are six monthly fire</p>

		<p>drills. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. There are sufficient first aiders to cover all shifts and van outings.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mat when activated light up on corridor lights that are visible from all areas in the facility. Security policies and procedures are documented and implemented by staff. The buildings are secure at night with after-hours doorbell access, which is connected to the call bell system. There is security lighting.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. Both rest home and hospital are very sunny. All heating is diesel. Staff and residents interviewed stated that this is effective. The entire site is smoke free.</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>The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. A registered nurse is the designated infection control coordinator with support and supervision from the facility manager and RNs who are members of the infection control team. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</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>A registered nurse is the designated infection control (IC) coordinator. The infection control coordinator receives supervision and support from the clinical facility manager. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and RN team have external support from the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Handwashing facilities are available throughout the facility and alcohol hand gel is freely available.</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>Infection control policies and procedures have been developed by the service and are reviewed annually. The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles and responsibilities.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has attended infection control training through the DHB and Ministry of Health on-line training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed at staff and clinical RN meeting. An external agency provides benchmarking. Meeting minutes including graphs are available to staff. Trends are identified, analysed and preventative measures put in place. A monthly report is forwarded to the trust board meeting.</p> <p>Systems in place, are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were four residents with restraints (bed loops and fall out chairs) and four using an enabler during the audit (bed loops) – link 1.3.5.2. Staff education on restraint minimisation and management of challenging behaviour has been provided in July 2017.</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>A restraint approval process is in place. The restraint coordinator role is delegated to a registered nurse. Four resident files reviewed, two for restraint and two for enablers all had a documented assessment and consent. All staff are required to attend restraint minimisation training annually.</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>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family, and observations by staff. A restraint assessment tool is in place, which meets the requirements of the standard.</p> <p>Four files of residents using restraints were reviewed and reflected appropriate assessments and consents. Links to their care plans were not always documented (link to 1.3.5.2).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Low	<p>A restraint register is in place. Restraint assessments reviewed identified that restraints are being used only as a last resort. As per the restraint minimisation policy, all restraints will be monitored a minimum of two-hourly. Monitoring documentation forms completed by staff did not reflect two-hourly monitoring while restraint was in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Restraint use is reviewed three monthly by the restraint coordinator. Strategies are implemented to reduce restraint use. At the time of the audit, four hospital-level residents were using a restraint.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and</p>	FA	<p>The restraint coordinator and facility manager complete the restraint programme, including reviewing policies and procedures and staff education. The staff training programme on restraint minimisation includes de-escalation and is reviewed annually.</p>

quality review of their use of restraint.		
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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)
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	Te Aroha has a quality process documented that includes an internal audit schedule and resident/family surveys. The facility manager is currently reviewing the audit schedule for the services. Not all audits and survey have been completed as per the current schedule.	Not all audits for 2017 and 2018 have been completed as scheduled. Since the draft report the provider has advised these are now up to date.	<p>Ensure that internal audits are completed as per schedule and reported.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring</p>	PA Low	The documented quality programme for Te Aroha includes an internal audit process, templates are in place	Action plans have not been documented for all	Ensure that shortfalls identified

<p>improvement in order to meet the specified Standard or requirements is developed and implemented.</p>		<p>for follow-up actions, but these have not always been completed where a shortfall has been identified.</p>	<p>internal audits where a shortfall has been identified, examples include the restraint audit for February 2018, and medication audit for September 2017.</p>	<p>through internal audit have an action plan documented and followed up.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Medications are prescribed electronically except for respite and GP referral which are paper-based. Pharmacy delivers the medications and checks them in with a RN. The pharmacy completes six-monthly checks of medications. All medications are stored safely. All medications that are no longer required are returned to pharmacy for disposal. 'As required' medications did not always have 'indications for use' documented.</p>	<p>(i) There has been no medication reconciliation for the respite resident on admission. There is no medication drug chart or signed GP order for staff to administer from. Medications are being administered to the resident from medication labels on medication bottles.</p> <p>(ii) Five out of fourteen 'as required' medications do not include indications for use.</p>	<p>(i) Ensure all respite residents have a written prescription.</p> <p>(ii) Ensure all 'as required' medications have indications for use charted.</p> <p>30 days</p>

<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Four out of seven care plans had interventions documented that supported needs and provided detail to guide care. A further four files were reviewed to review restraint/enabler use. Shortfalls were identified around interventions to support restraint/enabler use. There were six monthly reviews of care plans or more frequently where needs had changed. Multidisciplinary reviews also occurred.</p>	<p>(i) One hospital PACC resident has no current care plan in place (has been a resident five and a half months).</p> <p>(ii) One rest home resident who has commenced wandering had no interventions to manage the risks related to wandering in the care plan.</p> <p>(iii) One resident's care plan has been written before the completion of the interRAI assessment and had not been updated to reflect the interRAI assessment.</p> <p>(iv) The care plan of one resident with restraint does not include interventions to support restraint and</p> <p>(v) One resident with an enabler</p>	<p>(i) Ensure all PACC residents have a documented care plan.</p> <p>(ii) Ensure all residents have interventions documented to around assessed needs and risks.</p> <p>(iii) Ensure that care plan interventions reflect assessed needs identified through interRAI assessment.</p> <p>(v) –(vi) Ensure restraint is documented in the care plan and enablers are named.</p>
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			states 'enabler in use' but does not document what the enabler is or what interventions are required to minimise risk.	60 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	PA Low	The clinical assessment for the use of restraint is covered in the restraint assessment and includes the frequency of monitoring residents while restraint is in use. As per policy, all restraint monitoring will be conducted two-hourly unless stated otherwise. Restraint monitoring forms that were being completed for the two residents reviewed did not reflect two hourly monitoring. The restraint coordinator reports that monitoring is taking place two-hourly or more frequently, but is not being documented.	Two-hourly monitoring of restraint use was not reflected on the restraint monitoring forms for the two residents' files reviewed.	<p>Ensure monitoring forms reflect documented evidence of restraint use being monitored.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.