

Wairiver International Limited - Papakura Private Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Wairiver International Limited
Premises audited:	Papakura Private Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 10 March 2020 End date: 10 March 2020
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:	34

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

Papakura Private Hospital provides rest home and hospital level for up to 46 residents. There were 34 residents in the facility on the day of audit. The service is operated by Wairiver International Limited and managed by a director, an administration manager and a nurse manager. Residents and families spoke positively about the care provided.

This unannounced surveillance audit was conducted against selected criteria of 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, management, staff and contracted health providers.

There were seven areas identified requiring improvement relating to medications, planning of staff training, staff performance reviews, training records, interRAI assessment, menus, and equipment electrical checks.

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.	Green	Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required. A debriefing process has been introduced following adverse events that may cause stress or distress to staff.

The nurse manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints are resolved promptly and effectively. Follow up actions required after a complaint to the DHB in 2019 have been implemented.

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 medium or high risk and/or unattained and of low risk.
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Wairiver International Limited is the governing body and is responsible for the services provided at this facility. Quality and business and risk management plans are documented and include the scope, direction, goals/objectives, values and mission statement of the organisation. Systems are in place for monitoring the services provided, including regular monthly reporting by the nurse manager to the governing body.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse.

A quality and risk management system is in place which includes an annual schedule of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and that family satisfaction survey. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings with

discussion of trends and follow-up where necessary. Adverse events are documented on accident/incident forms and are seen as an opportunity for improvement. Corrective action plans are developed, implemented, monitored and signed off. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A suite of policies and procedures cover necessary areas, are current and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. All staff have received an orientation to their role. Ongoing training supports safe service delivery.

Staffing levels and skill mix meet contractual requirements. There is a roster of senior staff on call out of hours.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents are assessed prior to entry to the service to establish the level of care. The processes for assessment, planning, provision, evaluation, review and exit are provided by suitably qualified staff. InterRAI assessments and individualised care plans are documented.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP).

The food service is provided onsite and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. A food control plan was in place.

Safe and appropriate environment

<p>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.</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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A current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented. Safe external areas are provided for the use of residents.

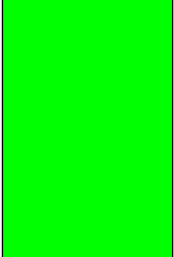
Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. There have been no alterations to the building since the last audit.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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There are clear and detailed documented guidelines on the use of restraints, enablers and management of challenging behaviours. There were five residents using restraint and none with enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in the management of challenging behaviours.

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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The infection surveillance programme is appropriate for the size and complexity of the organisation

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	13	0	2	3	0	0
Criteria	0	41	0	5	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy details the resident, staff, visitors and family member’s right to make a complaint. Guidelines are included in patient information on admission. Staff interviewed knew how to respond to and report a complaint. A complaints register is maintained. Nine complaints had been received since February 2017. A review of associated records verified that the complaints received since the last audit have been investigated and responded to in a timely manner.</p> <p>One complaint had been received via the Health and Disability Commissioner and one via the District Health Board. All required actions have been implemented. Refer to 1.2.7.5 – On-going education.</p> <p>Regular separate staff meetings for RNs, HCAs and household staff have been established and education provided at a level suited to their current knowledge base, relating to the classification of hospital level care in long stay residential care, the end of life process and making a complaint based on the MOH "making a complaint about your residential care" web resources. Education was also provided for the RNs relating to covering full team inclusion on a shift when any incident occurs so the full team concerns are addressed as appropriate at each level. Staff debrief sessions have been introduced at times of resident turnover due to death, especially in cases of multiple deaths in a short period of time, and for any adverse event that may have caused stress or distress to staff.</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>Family members stated they were kept well informed about any changes to their relative`s health 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 resident`s records reviewed. There was also evidence of resident/family input into the care planning process.</p> <p>Processes for open disclosure are documented that meet the requirement of the Code. Staff understood the principles of open disclosure. Examples were sighted in the records of adverse events. Following a complaint investigated by the DHB a process for debriefing staff after an in incident causing stress or distress to staff has been established.</p> <p>Interpreter services are available and accessible via the DHB if and when required. Staff know how to obtain an interpreter although this was rarely required due to a multicultural staff being able to provide interpretation as and when needed and the use of family members.</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>FA</p>	<p>Papakura Private Hospital has a documented mission statement and philosophy that is focused on the provision of individualised, resident focused care that maximises independence. The manager monitors progress in achieving goals via the internal audit process. The manager has an `open door` for residents and families. The quality/business plan was reviewed for 2020. A number of goals/objectives are set for the forthcoming year and these are monitored and documented once completed.</p> <p>The day-to-day operations and ensuring the wellbeing of residents is the responsibility of the manager who has worked at this facility since 1990. The manager is a registered nurse who is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency by attending management related education annually.</p> <p>The clinical nurse coordinator (CNC) resigned in January 2020 and a senior registered nurse is acting as clinical nurse coordinator (CNC) until the new clinical nurse coordinator commences duty at the beginning of April 2020. The manager and the CNC each have allocated responsibilities and goals to achieve as set out in the business plan. The current owners took over the lease of this facility 1 June 2017. One owner director is involved with the day to day management and the other director is responsible for the hospital intranet and all technology aspects of the business. Personnel changes in the last 18 months have included the administrator (four changes) and the clinical nurse coordinator (two changes). The current administrator has been in the role since November 2019.</p> <p>The service holds contracts with the DHB for rest home (RH), respite care, younger persons disabled (YPD), long term chronic (LTC), accident compensation corporation (ACC) and hospital level care. Thirty four residents received services under the contracts on the day of the audit: 1 rest homecare, 1 respite care, 3 ACC, 3 LTC, 4YPD and twenty two hospital level care.</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>FA</p>	<p>There is a quality and risk plan and this was sighted. Policies and procedures are available to guide staff practice. The policies are developed, authorised by the FM, implemented and reviewed regularly as per the documented review schedule. A secure archive store is maintained on site and is readily accessible if required. Policies and procedures are available to staff in electronic format and hard copy master manuals. Out of date policies are archived. Policies and procedures are developed and implemented to guide staff with appropriate references to interRAI being included to guide staff.</p> <p>The manager provides a monthly quality data analysis report in both narrative and graph format to the owner / director. The quality and risk programme is reviewed annually. The reports include individual resident's needs, complaints and compliments, changes to policies/procedures/practices, results of audits, staffing, education, the use of restraint, infection data and all types of incidents and quality related trends. The management team and the director have an 'open door' to staff and residents/families. This was verified by residents and family interviewed.</p> <p>Internal audits have been undertaken and are conducted using template audit forms. A schedule indicates what audits are to be undertaken and when. Audits sampled during the audit identified there is good compliance by staff in meeting the requirements of the organisation's policy and the audit criteria. Where improvements were required these improvements have been documented, implemented and monitored. Short term care plans are utilised to document follow-up for applicable incidents (e.g. falls management).</p> <p>An annual resident satisfaction survey is performed. The feedback is predominantly positive about the services provided. Staff have responded to any individual specific requests/comments raised by residents. The service provides a diverse range of services at this private hospital care setting.</p> <p>Resident meetings are held and minutes sighted reflected discussion on food, the activities programme, staff, laundry services and facility cleanliness. Resident compliments were recorded and communicated to staff. Education has been provided to residents on infection prevention and control topics during the resident meetings as needed.</p> <p>A risk management plan is in place. Organisation risks are categorised, documented and mitigation strategies noted.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded</p>	<p>FA</p>	<p>Policy and procedures detail the required process for reporting incidents and accidents, including notifiable events. Different template forms are used by staff to report events including infections, episodes of challenging behaviour, medicine related errors and incidents and accidents. Staff are provided with education on the responsibilities for reporting and management of accidents and incidents during their orientation and as discussions at shift hand over meetings.</p> <p>Applicable events are being reported in a timely manner and also disclosed to the resident and or designated next</p>

<p>by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>of kin. This was verified by residents and family members interviewed. The incident form includes an area to record that family were informed and who else was notified about the reported event (e.g. where applicable the RN, CNC and the resident's GP). A review of reportable events demonstrated that incident reports are completed, investigated and responded to in a timely manner. Changes were made to the resident's care plan where applicable or a short term care plan developed. Staff communicated incidents and events to oncoming staff via the shift hand over. Individual events are discussed with staff. Themes and trends are monitored and evaluated.</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>PA Moderate</p>	<p>Current copies of the annual practising certificates (APCs) for registered nurses and other health professionals who provide services to patients were sighted with the exception of the general practitioners which were out of date.</p> <p>The recruitment policy aligns with current good practices. This includes staff completing an application form and completing a health declaration, police vetting, interviews being conducted and reference checks obtained and retained. Staff have a signed employment agreement and confidentiality/privacy agreement on file. Performance appraisals have not been conducted since 2018.</p> <p>Records evidencing completion of the orientation programme were present in staff records. Staff interviewed report the orientation included being buddied with a senior staff member. The orientation included the facility, policy/processes, facility routine, staff tasks, and the individual resident's care needs.</p> <p>The regular ongoing education program has lapsed since January 2019. Staff indicated that some training is provided at special staff meetings and shift handover times.</p> <p>There are two registered nurses who have completed the interRAI training and annual competencies are maintained.</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>A policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider's contract with the DHB. The CNC and the FM are on site Monday to Friday. The owner /director is available Monday to Friday for day to day operational requirements.</p> <p>The last two months and the current roster were reviewed and demonstrated that all three wards have appropriate staff cover to meet the complex and diverse needs of residents in this specialised aged residential care facility. The roster is displayed daily on a whiteboard near the nurses' station. In addition to registered nurses and care staff there are three cleaners, one laundry person, one cook, a kitchen hand, two maintenance persons and activities personnel. All staff interviewed report that additional staff are provided if and when necessary. There is a clinical on-call system for the after-hours, with the CNC and the FM taking week about to cover the service.</p> <p>Residents and family members interviewed confirmed staffing meets their needs.</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>PA Moderate</p>	<p>The medicine management policy is current and identifies all aspects of medicine management in line with current legislation and protocols. There is a safe electronic medication system in place. There were no residents who were self-administering medications at the time of the audit. Appropriate processes are in place to ensure this is managed in a safe manner if required.</p> <p>An improvement has been identified regarding the documentation of pro re nata (PRN) medications.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>Diets are modified as required and the chef confirmed awareness of dietary needs of the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required. Residents and family/whanau interviewed acknowledged satisfaction with the food service. Kitchen staff completed training in food safety/hygiene.</p> <p>An improvement is required to ensure that the menu has been reviewed by the registered dietitian.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The assessment findings in consultation with the resident and/or family/whanau, inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans are used for short-term needs. Family/whanau and residents interviewed confirmed they are involved in the care planning process. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, accident compensation corporation (ACC) personnel, district nurses, physiotherapist, podiatrist, dietitian and GP.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in</p>	<p>FA</p>	<p>Interventions were appropriate to address the identified needs in the care plans. Significant changes were reported in a timely manner and prescribed orders carried out satisfactorily as reported by the acting clinical coordinator. One resident had no current interRAI assessment in place six weeks post admission (Refer 1.3.3.3). Specialist advice is sought from other service providers when required. Referral documents to other services and organisations involved in residents' support were sighted in the files sampled. Care staff confirmed that care is provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of</p>

order to meet their assessed needs and desired outcomes.		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>	FA	<p>Activities are appropriate to the needs, age and culture of the residents. The activities coordinator develops the activity planner and daily/weekly activities are posted on the notice boards. Residents' files have a documented activity plan that reflects the resident 's preferred activities of choice. Over the course of the audit, residents were observed being actively involved in a variety of activities. Activity plans were reviewed at least six monthly or when there was any significant change in participation, and this is done in consultation with the RNs. Activities range from group to one on one and cater for those under 65 years of age. The activities coordinator reported that residents assessed as long term chronic health and YPD are involved in all activities and this was noted in the files sampled. The activities vary from scrabble, bingo, music, movies, exercises/walking and church services every weekend. Activities are modified according to abilities and cognitive function.</p> <p>The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents and family members interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses complete progress notes daily and care staff every shift or as necessary. All noted changes by the care staff are reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals, occur every six months or as residents' needs change. These are carried out by the RNs in conjunction with family, GP and specialist service providers. Where progress is different from expected, the service was seen to respond by initiating changes to the service delivery plan.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	PA Moderate	<p>The current building warrant of fitness expires 28 July 2020 and is publicly displayed. The monthly Building Owners Checklists have not been maintained since November 2019. Appropriate systems are in place to ensure the residents` physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme for buildings, plant and equipment. The testing and tagging of equipment and calibration of bio medical equipment have not been maintained up to date. Hot water temperatures are monitored weekly and maintained at safe levels.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The environment is</p>

for their purpose.		conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance are required, any requests are appropriately actioned and that they are happy with the environment.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and 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 current fire evacuation plan was approved by the New Zealand Fire Service on the 20 February 1999. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service. 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, blankets, mobile phones and a gas barbecue are available on site. A water storage tank holding 2000 gallons of water is available. There is no generator on site, but one can be hired if required. Emergency lighting is installed and is tested annually.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells and this was observed during the audit.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked and checked regularly after hours.</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>	FA	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they are informed of infection rates at staff meetings and through compiled reports. GPs are informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p> <p>No infection outbreak was reported since the previous audit. Information on the management of the novel coronavirus was readily available for staff and visitors.</p>
Standard 2.1.1: Restraint minimisation	FA	The restraint minimisation and safe practice policy contains definitions and information that is congruent with the requirements of this standard. It states that the only approved restraints are bed-rails, adult sized bean bags and

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>soft harness. Policy includes processes for assessment, approval and consent, monitoring and review, evaluation and staff training. There were five residents using restraints and none using enablers during this audit.</p> <p>Staff training and information in relation to restraint and enabler use is ongoing. Information about the restraint policy is provided to new staff during orientation and reminders about restraint or enabler use is mentioned at monthly staff meetings. The staff interviewed could clearly differentiate between a restraint and an enabler and understood their responsibilities in regards to safe use of restraints and enablers.</p>
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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)
Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	Records of practising certificates for general practitioners who provide medical services to the facility were not available for audit.	There is no evidence that the general practitioners who provide medical services to the facility have current practising certificates	Obtain evidence that the general practitioners who provide medical services to the facility have current practising certificates 90 days

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>Staff education sessions required following a complaint investigated by the DHB in 2019 have been provided. Meeting minutes indicate that separate staff meetings for RNs, HCAs and household staff have been held and education provided at a level suited to their current knowledge base, relating to the classification of hospital level care in long stay residential care, the end of life process and making a complaint based on the MOH "making a complaint about your residential care" web resources. Education was also provided for the RNs relating to covering full team inclusion on a shift when any incident occurs so the full team concerns are addressed as appropriate at each level. Staff debrief sessions have been introduced at times of resident turnover due to death, especially in cases of multiple deaths in a short period of time, and for any adverse event that may have caused stress or distress to staff.</p> <p>Review of staff files indicated that performance reviews have not occurred since 2018 so training needs have not been identified. Review of staff education records and staff interviews indicated that the regular ongoing planned education program has lapsed since January 2019. Staff indicated that some training is provided at special staff meetings and shift handover times. The FM reported that education had been provided in relation to restraint in November 2019 and the corona virus in February 2020 but records were not available. Staff interviews confirmed that patient-specific training for management of special situations, e.g. patients on renal dialysis, were provided by a DHB renal dialysis nurse but again, records were not available.</p>	<p>i) No performance reviews have occurred since 2018 so training needs have not been identified. An ongoing training program has not been planned since 2018.</p> <p>ii) Training opportunities are provided but records are not consistently maintained. For example training provided by an external clinical expert for special care of renal dialysis patients has not been recorded.</p>	<p>Update all performance reviews, including identification of training needs.</p> <p>Develop, document and implement an annual ongoing training program.</p> <p>Maintain both session and individual records of all training undertaken by staff.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing,</p>	<p>PA Low</p>	<p>Residents receive medicines in a safe and timely manner. The service uses a pre-packed medication system and medicines are supplied by the contracted pharmacy. All medication packs are checked by the nursing team on delivery against the medication electronic system in use. Medicines held in stock are checked every month and any expired medicines are returned to the pharmacy promptly. There were no expired medications on site. The GP conducts three monthly reviews of medication charts.</p> <p>Controlled drugs are stored securely in accordance with requirements and</p>	<p>Medication charts reviewed did not have documented evidence of the effectiveness of PRN medication administered.</p>	<p>Provide evidence that the effectiveness of PRN medication administered is documented</p>

administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and all medications are stored appropriately. Medication is safely stored in locked cupboards and drug trolley. Documenting PRN medicines outcomes could be improved.		after use. 90 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	The enrolled nurse (EN) was observed administering medication correctly. All staff who administer medicines did not have current medication competency reviews in place.	Medication competencies are not reviewed annually as required.	Provide evidence that medication competencies for all staff who administer medications are reviewed annually and are current. 90 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	The food service is provided on site by a qualified chef and kitchen team and is in line with recognised nutritional guidelines for older people. There is a current food control plan in place. The menu is documented in a diary and residents' input is considered and acted upon. A nutritional profile is developed on admission and reviewed every six months or when there is any significant change. The menu has not been reviewed by the registered dietitian within the last two years.	There is no evidence that the current menu has been reviewed by a dietitian or nutritionist.	Provide evidence that the menu has been reviewed by a registered dietitian. 90 days
Criterion 1.3.3.3 Each stage of service provision	PA Low	Residents are admitted to the service when the required level of care assessments are completed and confirmed by the Needs Assessment Service Coordination (NASC) team. A care plan on admission is completed in a timely	InterRAI assessment was still not	Provide evidence that interRAI

<p>(assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>manner using information from the discharge summary, admission physical assessments, interviews, observations and NASC assessments.</p> <p>Residents' care plans are completed along with interRAI assessments however there was one resident who had no interRAI assessment in place</p>	<p>completed for one resident six weeks after admission.</p>	<p>assessments are completed within three weeks of admission.</p> <p>90 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>i)Review of the Building Owners Checklists relating to the Building Warrant of Fitness revealed that they had not been kept up to date at the required intervals since November 2019.</p> <p>ii) Records of the testing and tagging of equipment and calibration of bio medical equipment were not available for review. An equipment tag sighted on a hoist indicated it had not been checked since 2018.</p>	<p>i)The Building Owners Checklists related to the Building Warrant of Fitness have not been kept up to date at the required intervals since November 2019.</p> <p>ii)There is no evidence that electrical safety checks and calibration of measuring devices have occurred in the last 12 months.</p>	<p>Ensure that required checks and inspections are kept up to date.</p> <p>90 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.