

# Heritage Lifecare Limited - Waiapu House

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Heritage Lifecare Limited

**Premises audited:** Waiapu House

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 25 January 2021 End date: 26 January 2021

**Proposed changes to current services (if any):** The service provider is planning to add another seven dual-purpose bedrooms, two of which will have a shared ensuite. As a result of the reconfiguration of rooms, a fire wall is to be installed between living and service areas. This has not yet commenced, therefore was not part of this audit.

**Total beds occupied across all premises included in the audit on the first day of the audit: 66**



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Heritage Lifecare Limited-Waiapu House provides rest home and hospital level care for up to 74 residents. The service is operated by Heritage Lifecare Limited and managed by a care home manager, a clinical services manager and a unit coordinator. Residents and families spoke positively about the care provided.

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

The audit has identified three areas of improvements over two standards and related to the completion of maintenance tasks and adherence to the maintenance schedule, the need for a facility focused hazard register and the need to focus on the prevention of recurrence when reviewing clinical incidents.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents of Heritage Lifecare Limited-Waiapu House have The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) made available to them at the time of admission. Opportunities to discuss the Code, consent and availability of advocacy services is also provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs, and dignity of the residents. Staff were noted to be interacting with residents in a respectful manner.

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

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

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

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

Residents and family members are informed about the complaints process at the time of admission and reminded thereafter as relevant. A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		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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A facility-based business plan sits alongside an organisational one. These plans include the scope, goals, values and mission statement of the organisation and of the facility and link to separate quality and risk management plans. Monitoring of the services provided to the support office and the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

Ongoing reviews are ensuring quality and risk are being managed effectively with the collection and analysis of quality improvement data and identification of trends. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff are based on current good practice. External staff training opportunities are offered and internal training is delivered on a regular basis. Special topics and competency assessments are added to the education schedule as required to support safe service delivery. Annual staff performance reviews are up to date. Staffing levels and skill mixes are altered to meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using an integrated electronic and hard copy files.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The staff of Heritage Lifecare Limited-Waiapu House work closely with the local Needs Assessment and Service Co-ordination service, to ensure access to the facility is efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

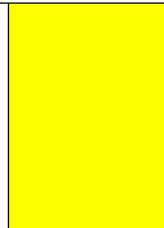
The planned activity programme is overseen by an activity's coordinator and two activity assistants. The programme provides residents with a variety of individual and group activities, seven days a week and maintains their links with the community. Two facility vans are available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## 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.



Some standards applicable to this service partially attained and of low risk.

Waste, soiled linen and equipment are well-managed, and chemicals are safely stored. Staff have access to, and use, protective equipment and clothing.

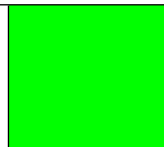
The facility meets the needs of residents and is clean. Refurbishment of the facility is ongoing. A current building warrant of fitness is on display. Electrical equipment is tested, and medical equipment calibration checks are completed as required. Communal and individual spaces are well ventilated and maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Laundry is undertaken onsite. Cleaning and laundry processes are evaluated for effectiveness through the internal audit system.

Staff are trained in emergency procedures and the use of emergency equipment and supplies. Fire evacuation procedures are practised according to requirements. Call bell response timeframes are monitored regularly, and security systems are maintained.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.



Organisational policies and procedures on restraint minimisation and safe practice are being implemented. At the time of audit, four enablers and five restraints are in use, with one person using two types. Comprehensive assessment, approval and monitoring processes with regular reviews are occurring. Use of enablers is voluntary for the safety of residents and is in response to individual requests. Staff demonstrate a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control officer, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from the Hawkes Bay District Health Board.

The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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)
<b>Standards</b>	0	48	0	1	1	0	0
<b>Criteria</b>	0	99	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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	Heritage Lifecare Limited-Waiapu House (Waiapu) has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day-to-day care on an ongoing basis.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service and contact details were also displayed in the facility. Family/whānau and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p> <p>The service also has three independent residents' advocates, one being the chaplain and two community members. Every second residents meeting (every four months) is run by the community advocates. The residents are enabled to speak openly with no Waiapu staff present. Any concerns that arise the advocates, if requested, address directly with the CM, who responds directly to the advocates. No meeting minutes of these meetings are kept. The community advocates were unable to be contacted for interview at the time of audit, however the chaplain was available for interview. The interview verified overall satisfaction with the service by residents. The chaplain was comfortable with the role of advocate and happy to address any residents concerns with management if asked. All past concerns have been addressed promptly and to the residents' satisfaction.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family/whānau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family/whānau interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaint management policy, procedure and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families/whānau on admission and those interviewed knew how to do so. Copies of the complaint process and the form are also available near the front reception.</p> <p>The complaints register reviewed showed that seven complaints have been received since the last audit in 2019 and that actions taken, through to an agreed resolution, are documented and have been completed within the required timeframes. Action plans show any required follow up and improvements have been made where possible. The care home manger, with support from the Heritage Lifecare quality manager as needed, is responsible for complaints management and follow up. All staff</p>

		<p>interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>One complaint received via the local District Health Board in May 2020, closed August 2020, was the only complaint received from an external source since the previous audit. Two earlier Health and Disability Commission (HDC) complaints (lodged 2018 and 2019) have been closed out since the last audit. One other complaint from this source lodged in 2018 remains open. Complaints from the HDC are managed through support office with feedback sought from the care home manager, and staff implicated in the complaint, when relevant. Records viewed confirmed actions recommended by the HDC have been followed up and implemented. These are specifically mentioned in the relevant sections of this report.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members of residents when interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and family members confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the nurse practitioner (NP). All residents have a private room with an ensuite.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There were three residents in Waiapu at the time of audit who identified as Māori. Interviews verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisors.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and family members of residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. There is a chapel on site and church services are held twice a week. A chaplain is available at Waiapu to provide church services. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A NP also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a code of conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, clinical nurse specialist, wound care specialist, services for older people, infection control nurse at the Hawkes Bay District Health Board (HBDHB), services for older people and mental health services for older persons, and education of staff. The general practitioner (GP) was unable to be contacted during the audit however a phone interview with the NP confirmed the service sought prompt and appropriate</p>

		<p>medical intervention when required and were responsive to medical requests. Interviews with the NP and the clinical manager (CM) verified the NP is used to provide medical input when the GP is too busy or unavailable. The GP practice has two NPs working for them.</p> <p>Staff reported they receive management support to attend external education by outside providers and access their own professional networks, and on-line learning hubs, to support good practice. RN's have access to comprehensive care guidance manuals, including Te Ara Whakapiri – principals and guidance to the last days of life. Recent pain management training by the hospice was provided in November 2020. Full facility wide external training opportunities for care staff to gain qualifications in care of the older adult is encouraged. There is a comprehensive in-service training programme that evidences good attendance records (refer criterion 1.2.7.5).</p> <p>Other examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided, evidenced by an ongoing initiative aimed at a reduction in the number of falls and a commitment to reducing the number of urinary tract and wound infections.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family/whānau members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family/whānau input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Attention to communication deficits identified by The Health and Disability Commissioner (HDC) are evidenced at this audit and have been addressed.</p> <p>Interpreter services can be accessed via the Napier District Court or the HBDHB when required. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</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>A business plan for 2020 was sighted. Six group overarching goals cover finances, residents and staff satisfaction, the provision of quality clinical care, health and safety and promotion of Heritage Lifecare Limited. An overview of goals for 2020 covers finances, residents, quality/clinical and health and safety, staffing and property and maintenance. Business requirements and measures of success are against each. Heritage Lifecare Limited-Waiapu House's own business plan was viewed and demonstrated how their own goals and action plans had been integrated into the organisation's template. Both business plans are currently under review for 2021. The care home manager provides quarterly reports on these goals to the support office alongside comprehensive monthly reports. Although quarterly reports had not been updated into the template for the final two quarters of 2020, the relevant information was</p>

		<p>described within the monthly reports that are also provided to support office via an operations manager. Copies of these documents were viewed.</p> <p>A Heritage Lifecare Limited document titled 'the Heritage Way' includes the organisation's vision of being a significant provider of aged care services throughout New Zealand especially in the area of residential care for older people. Its overall mission is: 'The continued pursuit of excellence in care through monitoring, auditing, actioning and evaluation of service whilst respecting and valuing our residents, families and staff' and its five underlying values are integrity, respect and value, commitment, effectiveness, and efficiency'.</p> <p>The service is managed by a care home manager who is a registered nurse with a current practising certificate and has been in the role for just over two years. This person has worked within the aged care sector for 12 years and held a range of management positions within other large, aged care providers and Heritage Lifecare Limited. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Currency of knowledge of the sector, regulatory and reporting requirements is being upheld via providing practical assistance to various staff as required, attending in-service sessions, regional conferences, aged care association updates and District Health Board forums. Additional support and information may be accessed from other managers within the wider organisation when required.</p> <p>The service holds contracts with the local District Health Board under the Aged Related Residential Care (ARRC) agreement including for respite and day services, long term support – chronic health conditions, restore and mental health. It also has one with Disability Support Services through the Ministry of Health for young person's with disabilities. Seventy rooms of this 74-bed facility are currently available for occupancy as four are being refurbished. One other is currently vacant. On the first day of audit there were 66 occupants as three residents were in the local hospital. Thirty-eight residents are receiving rest home care (although two are currently in the public hospital), and 31 hospital care (with one in the public hospital), under the ARRC agreement. One other person who is under 65 is under the long-term support - chronic health conditions contract.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to</p>	<p>FA</p>	<p>The clinical services manager carries out all the required duties under delegated authority when the care home manager is absent. If the absence is for an extended period, one of the roving managers from Heritage Lifecare Limited may be available, otherwise the operations manager, or one of the team from support office will assist or advise when required.</p> <p>During absences of the clinical services manager, the unit coordinator is able to take responsibility for any clinical issues that may arise. Additional support is available from a range of sources including a gerontology nurse specialist, a local nurse practitioner, the GP, other registered nurses within the team at Waiapu House and registered nurses from other Heritage Lifecare Limited facilities. Staff informed</p>



consumers.		they are very satisfied with the level of support currently available across all shifts.
<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 Moderate</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. Key elements of the quality program at the organisational level are the policies and procedures, the internal audit schedule and associated audit tools, care home health checks, education plans, quality alerts, clinical advisory group, benchmarking and key performance indicators, satisfaction surveys and external audits. At the care home level, the key elements are annual quality goals, internal audits, corrective action plans, quality action forms, incident reporting system, satisfaction surveys, education plans, quality meetings and complaints and compliments.</p> <p>A template for recording quality meeting minutes covers each of the above-mentioned aspects and minutes from the monthly quality and risk meetings at Waiapu House are being entered into these accordingly. Key clinical indicators have been identified as pressure injuries, falls, skin tears and bruises, near misses/other resident injuries, resident behaviours cause and concern, significant weight loss (unexpected), medication errors, restraint use and anything else. Meeting minutes confirmed that these are being analysed, reported against and presented to the quality team on a monthly basis. Reports from caregivers, household, laundry, maintenance and the kitchen are presented at each meeting.</p> <p>A meeting schedule for different staffing groups has been developed and these meetings are enabling information from quality team meetings to filter through the various departments of the facility. Meeting minutes are available for people who were unable to attend. Regular resident meetings are also being coordinated.</p> <p>Staff reported their involvement in quality and risk management activities through attending meetings, participating in internal audits, completing incident forms, and undertaking training and providing the best care possible for the residents. Relevant corrective actions are developed from internal audit processes and implemented to address any shortfalls with follow-up reports at subsequent meetings. Resident and family/ whānau satisfaction surveys are completed annually. The most recent survey showed similar levels of satisfaction to other Heritage Lifecare Limited facilities with additional comments made about meals and staffing. Several comments about call bell waiting times has seen the introduction of monthly print-offs of call bell response times and an analysis of waiting times. Survey results have yet to be presented to residents and family/whānau. Staff had opportunities to respond to survey questions following a 2019 road show led by the support office. One action point from the survey has been to ensure staff training sessions are more dynamic in nature.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. These are based on best practice and although there are ongoing reviews of the organisation's policy documents a</p>

		<p>number fall due for review in March 2021 are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>A risk management system describes the meaning of risk, includes a risk matrix/likelihood table and a consequence table. Organisational and workplace risks are measured using severity assessment codes (SAC) ratings of one through to four using the headings workforce, systems and processes, financial and environmental. The processes for the identification, monitoring, review and reporting of organisational risks and development of mitigation strategies are led by staff in the support office. All risk reporting comes through quality and risk management reporting systems. An overarching hazard register is available but is not specific for the Waiapu House environment and this requires correction. The care home manager and the village coordinator have completed relevant training and are familiar with the Health and Safety at Work Act (2015). Requirements have been implemented. Completed incident forms associated with service delivery related incidents are not necessarily identifying corrective actions or strategies to prevent a recurrence of the events.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans for management of the consequences of the incident documented and method of follow-up such as wound care plans were identified. However, as noted in 1.2.3.9 (b), these did not necessarily include corrective actions that applied to the specific incidents, nor were there action plans to prevent recurrence or to address the associated risks. Despite this, a range of clinical indicator data from incident data is being collated, analysed at the broader service provider level and reported to monthly quality and risk meetings. Action plans for improvement purposes are being developed at this wider level, even if not at the more personal resident risk level. Examples of these were the use of toolbox talks for staff reminders regarding documentation and practices and increased monitoring of some registered nurses by the clinical services manager.</p> <p>The care home manager described essential notification reporting requirements and is aware of the importance of responding to requests for information. They advised there has been one notification of a significant event made to the Ministry of Health, since the previous audit. Information related to this is still being sought from the coroner's office as the investigation progresses.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes presentation of an application and curriculum vitae, an initial interview, referee checks, police vetting and validation of qualifications and annual</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Any gaps in the information reviewed were from the previous owner and were historical.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and like the option for additional time being buddied if preferred. Staff records reviewed show documentation of completed orientation and a discussion with the care home manager after the third day, and after a three-month period.</p> <p>All new staff are being registered for training towards a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. As a result of a finding in the last audit, a concerted effort has been made to improve the number of previously employed caregivers with these qualifications and a creative plan is being implemented to achieve this; although Covid-19 restrictions have slowed its implementation. Two staff members are internal assessors for the programme, and another is an observer. A comprehensive continuing education schedule for staff is planned on an annual basis, including for mandatory training requirements. Attendance at the many education opportunities offered and participation in the various competency assessments are collated into a master spreadsheet, which when initially sighted had multiple gaps. During the audit, this was updated from a file of attendance records and the end result confirmed contractual requirements are being met.</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. Records sighted confirmed that specific staff, including registered nurses, kitchen, maintenance and activities staff complete first aid certificates, although all staff are encouraged to undertake a level of first aid training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster for the care home manager, the clinical services manager and the unit coordinator is in place, with staff reporting that good access to advice is available when needed. Caregivers interviewed reported there were adequate staff available to complete the work allocated to them, although expressed concern of night shift staffing levels. The care home manager had already informed the auditor that a review of staffing on night shift of one registered nurse and two caregivers was already underway and close to resolution with changes due when the planned new roster is implemented.</p> <p>Residents and families/whānau were full of praise for all staff and reported that exceptional care is being provided. Observations and review of a four-week roster cycle confirmed adequate staff cover has been</p>

		provided, with staff replaced, and shifts altered, to cover any unplanned absence. Agency nurses or carers are used if unable to cover such absences. With all registered nurses having a current first aid certificate, there is at least one staff member on duty who has a current first aid certificate. There is 24/7 registered nurse cover in the facility with three on duty most morning shifts, two on afternoons and one at night.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents are admitted to Waiapu when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service. Prospective residents and/or their families/whānau are encouraged to visit the facility prior to admission and meet with the Care Home Manager (CHM) or the CM. Prospective residents are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the organisations transfer form and the HBDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family/ whānau. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-</p>

		<p>ordinated manner. Family/whānau of the resident reported being kept well informed during the transfer of their relative.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer or check medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP/ NP review is consistently recorded on the electronic medicine chart.</p> <p>There were three residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the CHM, CM and unit coordinator and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Waiapu.</p> <p>A request by HDC to verify residents receive prescribed medications in a timely manner when required, has been evidenced as occurring at this audit.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian 15 January 2021, Recommendations made at that time have been implemented.</p> <p>An up-to-date food control plan is in place and verified for eighteen months by the Hastings District Council 11 August 2020, due to expire February 2022.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family/whānau interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. There are two dining rooms at Waiapu. One for residents requiring no assistance and the other where assistance with meals is required. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p> <p>The introduction of a recent smorgasbord breakfast at Waiapu has the approval of residents. Those who desire and are able, can get up and go to the dining room and help themselves to a selection of cereals, porridge, toast and hot drinks. A hot breakfast cooked as requested, is available between 0745 and 0815.</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>	<p>FA</p>	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family/whānau. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission residents of Waiapu House are initially assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, behaviour, and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least every six months unless the resident's condition changes. Interviews, documentation, and observation verifies the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by six trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>All 12 care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities note, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families/whānau reported participation in the development and ongoing evaluation of care plans. Any change in care required because of an event or incident was well documented and implemented, however the analysis of the event or incident to identify possible actions to be taken to prevent recurrence was not well addressed (refer criterion 1.2.3.9).</p> <p>A request by HDC to verify residents care plans are resident focussed, integrated and promote continuity of service, is evidenced to be occurring at Waiapu at the time of audit.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	<p>FA</p>	<p>Documentation, observations, and interviews verified the provision of care provided to residents in the 12 files reviewed was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided</p>

desired outcomes.		<p>and in accordance with the residents' needs.</p> <p>A request by HDC to verify residents at Waiapu receive adequate and appropriate services to meet their assessed needs and desired outcomes has been substantiated at the time of audit.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by an activities coordinator and two activities assistants, two of which are in training to be diversional therapists, with the other to commence training. The activities programme is provided seven days a week and is reviewed by a qualified diversional therapist prior to being implemented.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activity programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal activities plan review every three months.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included an exercise programme, walking programme, knitting groups, bowls, church services, movies, baking, visiting entertainers, quiz sessions, van outings and daily news updates. The activities programme is discussed at the bimonthly residents' meetings and minutes indicated residents' input is sought and responded to. A questionnaire to residents is also circulated requesting resident's input into what activities they would like. Theme months occur at Waiapu, and the themes include meals and activities that relate to that theme. Resident and family satisfaction surveys demonstrated satisfaction. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans are consistently reviewed to ensure effectiveness in addressing the immediate need and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>



<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. When the GP from the services main service provider is unavailable, the practice has two NPs that are able to assist. If the need for other non-urgent services is indicated or requested, the GP/NP or CM sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the CM or the GP/NP. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and infectious and hazardous substances are in place for staff to implement. Contractors are involved in the removal of general waste, medical waste and recyclables, which is collected at the rear of the kitchen.</p> <p>Appropriate signage is displayed where chemicals and hazardous substances are stored. These were viewed in sluice rooms, the cleaning room, laundry and a key storage room. Material safety data sheets are in these storage areas. Staff receive training from an external company, which is contracted to supply and manage all chemicals and cleaning products. Spill kits are available should a chemical spill/event occur.</p> <p>Personal protective clothing and equipment are available to staff throughout the facility and staff were observed using these items. Staff confirmed having received training on its use.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>A current building warrant of fitness with an expiry date of 1 March 2021 is on public display near the front entrance.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with managers and observation of the items. Records of monthly checks of hot water temperatures confirm they are at safe levels. Workplace inspection checklists are being completed monthly and efforts are made to ensure the environment is hazard free and residents are safe. However, information from staff interviews and records sighted confirmed reports that the organisation's maintenance schedule is not being adhered to and maintenance tasks in the maintenance book are not being completed in a timely manner.</p>

		<p>The external areas, which are appropriate to the resident groups and setting, are being kept safe. Although gardens around the facility are currently in need of general maintenance, this is expected to be resolved when a new gardener commences in early February. A residents' garden area with raised beds and pots is well tended and thriving.</p> <p>Residents confirmed they are happy with the environment and its spaciousness, appreciate the renovations progressively occurring and enjoy the designated residents' garden area they are being assisted to maintain.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All residents' rooms have an ensuite bathroom with a shower, hand basin and toilet. Five separate toilets throughout the facility are available for resident use and there is a bathroom with a bath in it. Appropriately secured and approved handrails are installed in all toilet/shower areas, and other equipment/accessories are available to promote resident independence.</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>Overall, residents' bedrooms are on the larger size, which enables residents and staff to move around within these rooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters within residents' rooms and in dedicated storage areas throughout the facility. Staff and residents confirmed the adequacy of bedrooms.</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>A variety of communal areas are available for residents. In addition to four smaller lounges and several sitting areas with garden views, there are two large dining rooms and two spacious lounge areas. All enable easy access for residents and staff and three have communal televisions. A separate large activity room is an asset for residents. The wide variety of communal areas provide residents with options of places to go for privacy, if desired. Furniture is appropriate to the setting and residents' needs and there is sufficient space for people in wheelchairs.</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>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry. The key laundry worker was interviewed and demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. A good knowledge of laundry management and use of personal protective equipment in the event of a pandemic was demonstrated. Family members interviewed reported the laundry seemed to be managed well and residents informed their clothes are returned in a timely manner.</p> <p>Two members of a small team of cleaning staff were interviewed and informed they have received appropriate internal training, especially about infection prevention, as well as updates from the supplier of the cleaning products. During the interview, both focused on the safety precautions needed with the storage and handling of the cleaners, were aware of the function of the different products and of maintenance of their equipment. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Documentation that describes both laundry and cleaning schedules and processes was reviewed. Cleaning and laundry processes are monitored through the internal audit programme and examples of the most recent audits were sighted. The staff described the outcomes of these as learning opportunities and noted appropriate changes had been made.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Comprehensive 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 8 March 2011. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service. The most recent was 21 June 2020 with the next scheduled for 10 February 2021. The 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 a radio, spare batteries, torches, blankets, medical equipment and gas BBQs for example were sighted and meet the Ministry of Civil Defence and Emergency Management recommendations for the region. The pandemic, outbreak and civil defence supplies were in a muddle at the commencement of the audit; however, the cupboard was subsequently tidied and the scheduled six-monthly checklist redone to confirm requirements were met. A water storage tank with over 2000 litres sits in a cupboard in a garden area and food supplies for at least five days are consistently kept in the kitchen area to manage any adverse event that may occur. Records confirmed emergency lighting is regularly tested and infection outbreak kits are checked monthly. Clear illustrated instructions for turning off gas, electricity and power were viewed in the emergency supply room.</p> <p>Call bells alert staff to residents requiring assistance. Call system response time audits are now</p>

		<p>completed on a monthly basis following concerns raised about the length of time to get a bell answered during the last resident survey. The unit coordinator reviews the electronic call bell system records and follows up any patterns that emerge.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises randomly twice each night. Security cameras have recently been installed in non-personal resident areas and signs informing of this were viewed.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows with limited opening for security purposes and there is a large skylight in an open area near the middle of the building. Five rooms have ranch slider doors that open onto outside garden areas. Separate dedicated smoking areas for staff and residents meet requirements.</p> <p>There is underfloor heating in residents' rooms and in communal areas of one part of the building. A mix of wall-mounted fan heaters, convection heaters and panel heaters are in another. Areas were well ventilated and a pleasant temperature throughout the audit despite very warm external temperatures. Air conditioning units are in one of the large lounges, in the two alcoves near the dining room in one wing and in the activity room in the other. Residents and family whānau confirmed that as far as possible the facility is maintained at a comfortable temperature throughout the year.</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 service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the CM. The infection control programme and manual are reviewed annually.</p> <p>The RN with input from the CM is the designated infection control officer (ICO), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the organisations quality team and tabled at the quality/risk meeting. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisations national quality manager is informed of any IPC concern.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</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>	<p>FA</p>	<p>The ICO has appropriate skills, knowledge, and qualifications for the role, however, has been in this role for only a short time and is being assisted by the organisations quality manager. The ICO has undertaken relevant and recent training in infection prevention and control as verified in training records sighted. Well-established local networks and attendance at meetings with the Infection Prevention and Control Support Group (IPCSG) at the HBDHB, are available. The ICO has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICO confirmed the availability of resources to support the programme and any outbreak of an infection. The organisation continues to be prepared for an outbreak of Covid-19 and is well supported by the IPCSG and the organisations quality team.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons, masks and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICO. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.</p> <p>Training on preparedness for Covid-19 remains ongoing. During 2020, the organisation and the HBDHB provided on-site training and videos to ensure staff were aware of how to keep themselves safe during</p>

		<p>an outbreak, including the correct use of personal protective equipment (PPE). Staff interviewed demonstrated awareness of keeping themselves and the residents safe.</p> <p>Education with residents is generally on a one-to-one basis and has included education on keeping safe during Covid-19 alert levels, reminders about the use of masks, handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p>
<p><b>Standard 3.5: Surveillance</b></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>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICO reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>A recent analysis of wound infection data identified a high rate of wound infections at Waiapu. A presentation at the ICPSG identified a correlation between increased wound infections and the use of wound trolleys that stored wound care products, as well as being used for dressings. An initiative was implemented by the ICO whereby the trolley only carries the product to be used to do that dressing. All other products are stored in a central area. After the wound has been attended to, the trolley is cleared, cleaned, and left empty. A review of wound infections has in the initial phases evidenced a decrease in wound infections from eleven to four over three months. It is however too early to do a comprehensive evaluation at this stage.</p> <p>A good supply of personal protective equipment is available. Waiapu has processes in place to manage the risks imposed by Covid-19.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, four residents were using bedrails as restraints, one of whom was also using a</p>

<p>minimised.</p>		<p>pelvic brief as a restraint, and four residents were using enablers, all of which were bedrails. The enablers in use were the least restrictive options and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is reportedly used as a last resort when all alternatives have been explored. Individual assessment plans were evident in documentation sighted including the resident's personal file and restraint reports as well as during interview with the restraint coordinator.</p> <p>Records confirmed that all staff involved in resident care have undertaken training and completed a competency in relation to restraint and enabler use. Those interviewed responded appropriately to questions in relation to the use of restraints and enablers.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>Policy documentation and associated forms guide the restraint approval process. Members of the restraint approval group, which is made up of the restraint coordinator, the clinical services manager, unit coordinator and a senior caregiver, are responsible for the approval of the use of restraints and the restraint processes. This process is completed in consultation with the general practitioner and/or nurse practitioner.</p> <p>It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</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>	<p>FA</p>	<p>One of the registered nurses is the restraint coordinator. The restraint coordinator becomes involved in the assessment process for any restraint use. Input is sought from the resident's family/whānau/EPOA and ultimately the resident's GP or nurse practitioner during this process.</p> <p>Completed assessments for the use of each restraint for each of the affected residents were documented and records sighted included the review of any potential risks. The restraint coordinator confirmed that underlying causes of the presenting concerns indicating the need for a restraint are considered, as are known historical factors that could contraindicate its use. Safety considerations are discussed and family/whānau/EPOA sign and date their involvement in the assessment. Staff reported the desired outcome is to ensure the resident's safety and security at all times.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>At the service provider level, the use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family/whānau members as relevant. Alternatives observed to already be in use include the use of sensor mats, low beds and increased monitoring of any resident at risk.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and the advocate interviewed during the audit confirmed this. The restraint coordinator and caregivers interviewed described the importance of ensuring the residents' dignity and privacy are maintained and respected at all times.</p> <p>A restraint register is maintained, updated every month and reviewed at each monthly restraint approval group meeting. The register was reviewed and included all residents currently using a restraint and sufficient information to provide an auditable record. The January 2021 register demonstrated that discussions had been undertaken with one family member and the restraint has since been removed. A person using bedrails as an enabler has agreed to using one bedrail only, to enable self-mobility in bed, rather than bedrails on both sides to feel safer. This is being monitored.</p> <p>In addition to staff training on restraint use and safety, additional education on de-escalation techniques and how to manage people with challenging behaviours was recorded in staff training records. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, three monthly restraint evaluations and at the restraint approval group meetings. The restraint coordinator informed that they have led a change within this service for evaluations to occur three-monthly rather than the six-monthly requirement noted within the policy. Three residents' records sighted of the evaluation process confirmed family/whānau are involved in the evaluations and all were comfortable with the use of restraint in these instances.</p> <p>There are documented records of the evaluations of restraint use for each resident, as relevant. The restraint coordinator also described how these are covered and meeting minutes included notes on the strategies in use towards eliminating the restraints in use, the impact and outcomes achieved, if the policy and procedure was followed and whether documentation has been completed as required.</p>
<p>Standard 2.2.5: Restraint</p>	<p>FA</p>	<p>The restraint committee meets monthly prior to each quality and risk meeting and the restraint coordinator develops a report which is then presented at the quality and risk meeting and subsequently</p>



<p>Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>attached to those meeting minutes. Meeting minutes reviewed confirmed this process. The three-monthly individual reviews of all restraint use are included in these reports. In addition, restraint use is a component of the monthly clinical indicators report developed by the clinical services manager, which includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and whānau/families. A six-monthly internal audit that is carried out also informs these meetings.</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)
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change</p>	<p>PA Moderate</p>	<p>An organisational risk register and hazard register are available. Risks are managed via the quality and risk management system. However, there is not currently a facility-specific hazard register for Waiapu House.</p> <p>A review of incident report forms confirmed these are being completed. The forms include a section intended to record any corrective actions required, or any action plans that might help prevent a recurrence of the incident. Examples of clinical related incident reports sighted did not clearly identify action plans that would reduce potential risks associated with such an incident or reduce the risk of recurrence.</p>	<p>(a) There is not currently a facility-specific hazard register that would enable environmental and task related risks at Waiapu House Lifecare to be monitored.</p>	<p>(a) A facility specific hazard register is developed, regularly reviewed and updated as required.</p> <p>(b) The section of the incident form for the recording of</p>

<p>in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>			<p>(b) Individual clinical incidents are not all being analysed in a manner that identifies risks associated with service provision to be addressed and treated.</p>	<p>any corrective action, or to document suggestions to prevent recurrence, is completed as relevant to enable potential risks associated with service provision go be identified and addressed.</p> <p>90 days</p>
<p>Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>Workplace inspection checklists are being completed monthly and the managers informed that efforts are made to ensure the environment is hazard free. Key maintenance tasks of testing and tagging of electronic equipment, the calibration of bio-medical equipment and monthly checks of hot water temperatures for example are being completed and recorded. An annual maintenance schedule for the facility that includes six monthly checks of the functioning of call bells, two monthly wheelchair cleaning and safety checks and vehicle checks for examples was viewed. The last records for any of these tasks having been completed were dated 30 March 2020 and there was no evidence to confirm the listed tasks are being completed as required. A maintenance record book, which has space for signing and dating when repairs or specific tasks have been completed, is in use. A number of records, some of which have the potential to endanger people's health and safety, have not yet been signed off as completed, nor warnings conveyed, despite being reported more than seven to ten days previously. Two examples include a broken taillight on the facility van</p>	<p>There are limited records available to demonstrate that tasks on the organisation's monthly maintenance schedule are being completed as required.</p> <p>Multiple tasks, some of</p>	<p>The annual maintenance schedule is upheld, and any repairs presenting health and safety risks are completed safely within a timely manner.</p> <p>90 days</p>

		and unstable tiles presenting trip hazards.	which have health and safety implications, have not been signed off as completed in the maintenance record book in a timely manner.	
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.