

Whangaroa Health Services Trust - Whangaroa Health Services

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Whangaroa Health Services Trust
Premises audited:	Whangaroa Health Services
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 March 2021 End date: 17 March 2021
Proposed changes to current services (if any):	Seven rest home level rooms were assessed as suitable for hospital level of care.
Total beds occupied across all premises included in the audit on the first day of the audit:	25



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Whangaroa Health Services Trust operates an aged residential care service, the Kauri Lodge, and a community health programme (community fitness, health and well-being and children's oral health). The Kauri Lodge has 25 beds and provides rest home and hospital (geriatric and medical) levels of care. On the day of the audit there were 25 residents. A general manager oversees operations of this health service.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and general practitioner. In addition, seven rest home level rooms were verified for their suitability for hospital level of care.

A general manager oversees operations for the Whangaroa Health Trust. Kauri Lodge is managed by an interim clinical manager (registered nurse) who has been working at the facility as a registered nurse for two years. Family and residents interviewed spoke positively about the care and support provided.

This audit identified that improvements are required in relation to staff orientation, staff education, neurological assessments following a resident fall, the hazard register, integration of residents' files, access to cleaning chemicals, and the building warrant of fitness.

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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Whangaroa Health Services Trust endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrated an understanding of residents' rights and obligations. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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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Services are planned, coordinated, and are appropriate to the needs of the residents. An interim clinical manager/registered nurse (RN) is responsible for the day-to-day operations of Kauri Lodge. Quality and risk management processes are documented and implemented. Adverse, unplanned and untoward events are responded to in a timely manner. Appropriate employment processes

are adhered to. An education and training programme for staff is established. Care staff and residents reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nurses are responsible for each stage of service provision. Residents' records reviewed, provided evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. These are then reviewed and discussed with the resident and/or family/whānau input. Care plans are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

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

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times. A contracted dietitian reviews the organisation's menu plans.

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 medium or high risk and/or unattained and of low risk.
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Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

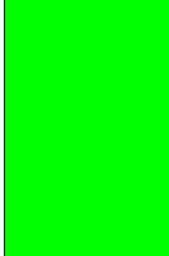
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Staff are provided with access to training in restraint minimisation and challenging behaviour management. At the time of audit there were six residents using restraints and one resident using an enabler. The approval process for restraint use includes ensuring the environment is appropriate and safe.

Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. Restraint use is reviewed a minimum of three-monthly.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (acting clinical manager) is responsible for coordinating education and training for staff. The infection control nurse has completed annual training provided internally online and has access to external training provided by the local DHB. There is a suite of infection control policies and guidelines available electronically to support practice. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service plans to engage in benchmarking with other local facilities. There has been one gastro viral outbreak in the previous year which was appropriately managed.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	4	3	0	0
Criteria	0	93	0	5	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location in English and in te reo Māori. Policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training (link 1.2.7.5). Interviews with the managers (general manager, interim clinical manager) and eight staff (two healthcare assistants (HCAs), two registered nurses (RNs), one cook, one diversional therapist, one maintenance, one administrator) confirmed their understanding of the key principles of the Code and with examples provided of how the Code applies to their job role and responsibilities.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in five resident files (three hospital, including one long term services – chronic health care [LTS-CHC], and two rest home, including one YPD) were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Healthcare assistants (HCAs) and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care.</p>

<p>choices and give informed consent.</p>		<p>Discussion with family members confirmed that the service actively involves them in decisions that affect their relative's lives.</p> <p>Five resident files of long-term residents have signed admission agreements.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy support services is included in the resident information pack that is provided to residents and their family on admission. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy support services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do.</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 complaints procedure is provided to residents and relatives at entry to the service. A record of complaints, both verbal and written is maintained electronically by the general manager using a complaints' register. The complaints process is linked to the quality management system. There has been only one complaint lodged since the previous audit. On review of this complaint, it was managed appropriately and has been signed off by the general manager as resolved.</p> <p>Residents and family members advised that they are aware of the complaint procedure. Discussion around complaints and/or concerns are included in staff meetings.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>	<p>FA</p>	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The interim clinical manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the two-monthly resident/family meetings. Interviews with five residents (three rest home and two hospital) and three relatives (one hospital and two rest home) confirmed that the residents' rights are</p>

their rights.		being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.
<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 are treated with dignity and respect. Privacy is respected, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identified residents preferred names. Values and beliefs information are gathered on admission with family involvement and are integrated into the residents' care plans. Spiritual needs are identified. There is a policy on abuse and neglect and staff have access to regular training (link 1.2.7.5).</p> <p>Residents are assisted and supported to maintain as much independence as possible.</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>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There were six residents who identified as Māori at the time of the audit. One file reviewed and interview with a resident who identifies as Māori indicated that their values and beliefs are identified in their care plan and are acknowledged and respected by staff.</p> <p>Māori consultation is available through documented iwi links. HCAs interviewed, including one HCA who identifies as Māori, were aware of the importance of whānau in the delivery of care for Māori residents. A selection of the HCAs can speak te reo Māori to the residents, observed during the audit. The new clinical manager, who begins work in one week, also identifies as Māori.</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>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they are involved in developing the resident's plan of care, which includes the identification of individual values and beliefs. All care plans reviewed include the resident's social, spiritual, cultural and recreational needs.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Code of conduct training is provided through the in-service training programme (link 1.2.7.5). Professional boundaries are defined in job descriptions. Interviews with healthcare assistants confirmed their understanding of professional boundaries, including the boundaries of the healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions (link 1.2.7.5), staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available 24 hours a day, seven days a week. A general practitioner (GP) visits the facility two days a week. A full-time nurse practitioner, who is responsible for the community health programme, is also available on the premises. After hours clinical service is through Whangarei Hospital.</p> <p>The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. Physiotherapy services are provided approximately two hours per week with a physiotherapy assistant assisting nine hours per week. A podiatrist is on site every six weeks. The service has links with the local community and encourages residents to remain independent.</p> <p>Standards of infection control throughout the 2020 pandemic situation remained robust, with fewer infections in general for both residents and staff. All staff have complied with the request to be Covid tested where appropriate.</p> <p>Kauri Lodge has a particular focus on providing excellent end of life care and palliative services, encouraging whānau to be beside their loved ones and participate in their care. The staff work closely with hospice.</p> <p>Recent improvements include improvements to the call bell system, water management system, and garden enhancements. Work is underway to re-establish fire walls (link 1.4.2.1).</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>There is a policy to guide staff on the process for open disclosure. Residents/relatives have the opportunity to feedback on service delivery through open-door communication with management. Two-monthly resident meetings encourage open discussions around the services provided (meeting minutes sighted). Accident/incident forms reviewed provided evidence that families are informed of incidents/accidents. Families interviewed stated they are notified promptly of any changes to residents' health status including any incidents or accidents.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required through the DHB.</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>Whangaroa Health Services is governed by a trust board, comprised of representatives from the local community. A (non-clinical) general manager oversees the Whangaroa Trust operations; Kauri Lodge, the aged care facility; and a community health programme. He has a business and tertiary education background and has been in this role for the past 15 months. He is supported by an interim clinical manager who previously was a staff RN. This role has been vacant for the past two weeks. A new clinical manager has been appointed who will begin employment on 22 March. She is a registered nurse who identifies as Māori. She was previously employed as a registered nurse at Kauri Lodge from 2015-2017 and has been employed in the primary health sector as a practice nurse since 2017. She holds a current CPR level five certificate.</p> <p>Kauri Lodge is certified for up to 25 residents. Ten beds are dedicated rest home level beds, and the remaining fifteen beds are suitable for either rest home or hospital level care. On the day of the audit, the facility was fully occupied with 25 residents (18 rest home level, and 7 residents at hospital level). One resident (hospital) was on a long-term service - chronic health condition (LTS-CHC) contract and two residents (one hospital, one rest home) were on a younger person with a disability (YPD) contract. All remaining residents were under the DHB age-related residential care services agreement.</p> <p>A 2020-2022 strategic plan for the Whangaroa Health Services Trust is in place that describes the vision, purpose, values and goals for the trust. An annual quality assurance and risk management plan lists operational objectives and is linked to key performance indicators (KPIs). Monitoring of these KPIs is linked to the internal auditing programme.</p> <p>The general manager has completed a minimum of eight hours of professional development activities related to his job role and responsibilities.</p> <p>Partial provisional audit: This audit also assessed the suitability of seven rest home level beds for hospital level care. These rooms are currently occupied with rest home level residents. The general manager and interim clinical manager interviews confirmed that changing these rooms to dual-purpose (rest home or hospital level of care) provides greater flexibility by the service and will assist in meeting the needs of the community.</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</p>	<p>FA</p>	<p>The general manager is supported by an administrator and the interim clinical manager in his absence. The current interim clinical manager will support the recently hired clinical manager with clinical operations in their absence.</p>

<p>efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>Kauri Lodge, under the direction of the Whangaroa Health Trust, has implemented a quality system that was purchased from an external consultant (Healthcare Compliance Solutions Ltd [HSCL]). System components cover the collection, collation and reporting of data (eg, incidents/accidents, complaints [if any], infection control, restraint use) and the development of corrective actions where opportunities for improvements are identified. Staff interviewed confirmed that they are actively involved in the quality management systems being implemented.</p> <p>Policies and procedures implemented provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. There are clinical policies/procedures to support hospital and rest home level care. Policies and procedures are regularly updated with assistance provided by HSCL.</p> <p>An internal audit programme is being implemented as per the audit schedule. Service meetings include a monthly clinical meeting, a monthly staff meeting, and a two-monthly residents' meeting. Regular agenda items include accidents/incidents, infections, complaints, training, internal audit results, corrective actions, health and safety and restraint minimisation. Meeting minutes reflect quality results being discussed with staff. A satisfaction survey was completed two years ago with plans in place to repeat the survey in 2021.</p> <p>Where internal audits reflect areas for improvement, a corrective action plan is generated and transferred to a corrective action register. Corrective actions that reflect improvements are either signed off when resolved or are signed off when the audit has been repeated and meets the acceptable target.</p> <p>There is a health and safety, and risk management system being implemented. The hazard register is overdue for review.</p> <p>Falls management strategies include assessments after falls and developing individualised strategies to prevent falls from reoccurring.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	<p>PA Low</p>	<p>The service collects incident and accident data and enters this information into an electronic register for data collation and analysis. The system provides monthly reports, which are then discussed at the staff meetings.</p> <p>There were 10 resident-related incident forms reviewed that are documented electronically. All incident forms (one pressure injury, two episodes of challenging behaviour, two skin tears and five falls) identified a timely RN assessment of the resident and corrective actions to minimise resident risk and reoccurrence.</p>

<p>the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Neurological observations were completed for three unwitnessed falls but did not consistently follow protocol. The HCAs interviewed could discuss the incident reporting process. The interim clinical manager investigates and signs off on all incident reports.</p> <p>The interim clinical manager interviewed could describe situations that would require reporting to relevant authorities. There were Section 31 notifications completed for a pressure injury, RN shortages and one outbreak.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>There are human resources management policies in place. Six staff files were selected for review (two registered nurses and four healthcare assistants). Signed employment agreements and job descriptions were sighted. Copies of practising certificates for RNs and external health professionals were sighted.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed could describe the orientation process and stated that they believed new staff were adequately orientated to the service. Missing in a selection of staff files was evidence that the orientation programme was completed.</p> <p>Review of the in-service education programme for 2020 reflected less than eight hours of training per person. Online training is available for staff but interviews with the healthcare assistants indicated that they are reluctant to engage in online learning.</p> <p>Two of five registered nurses have completed interRAI training. An additional RN with interRAI training is currently on maternity leave.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A roster is in place which provides sufficient staff cover for the provision of care and service to 25 residents.</p> <p>The interim clinical manager (RN) is rostered Monday to Friday and on call. A registered nurse is rostered each shift. Additional RN staffing is rostered to complete interRAI assessments (as needed).</p> <p>Rose Wing (ten rest home level residents) is staffed with one healthcare assistant on each shift.</p> <p>Tui Wing (eight rest home and seven hospital level residents) is staffed with one long shift healthcare assistant on the AM shift and one short shift (to 1 pm), and one long and one short healthcare assistant (9.30 pm) on the PM shift.</p> <p>Night shift: There is one healthcare assistant to support the rostered RN.</p> <p>Note: Due to RN shortages, the DHB supplied Kauri Lodge with an interim RN until one could be recruited and could travel under the Covid pandemic level three.</p>

		<p>Staff are employed specifically for housekeeping, laundry and kitchen duties. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p> <p>Partial provisional: The interim clinical manager interviewed advised that additional staff can be rostered to meet additional needs of the residents. Currently all beds are occupied. RN staffing would be increased with an occupancy of 19 hospital level residents or more.</p>
<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>	<p>PA Moderate</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas. Electronic files are backed up using cloud-based technology. Medical notes are not integrated into the electronic resident file, being held on a separate system to which the nurses have no access. Entries into the resident file are legible, timed, dated and signed electronically by the relevant HCA or RN, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The general manager and clinical manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The five admission agreements reviewed meet the requirements of the ARCC and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the general manager or clinical manager are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a</p>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. One file reviewed was of a resident</p>

<p>planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>who had been transferred to hospital acutely for an x-ray. All appropriate documentation and communication were completed. Transfer to the hospital and back to the facility post-discharge was well documented in progress notes. Communication with family was made in a timely manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Partial provisional: The additional seven beds in the rest home wing, assessed by the auditors as suitable for hospital level of care, would use the same medication room as the dual-purpose wing. Both wings are located on the same (ground) level and are in close proximity to each other. (Note: The medication room is located in the dual-purpose wing.)</p> <p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. All legal requirements had been met. There are no standing orders in use. There are no vaccines stored on site. All clinical staff (RNs and med comp HCAs) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses and an HCA interviewed could describe their role regarding medication administration. The service currently uses the medico blister pack system for regular medication and 'as required' medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the medication room. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All medications including the bulk supply order is checked and signed for weekly. All eyedrops have been dated on opening.</p> <p>Staff sign for the administration of medications electronically using 1chart. Ten electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. 'As required' medications had indications for use charted.</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</p>	<p>FA</p>	<p>A kitchen manager oversees the on-site kitchen, and all meals are cooked on site. There is a seasonal four-week rotating menu, which is reviewed by an external consulting dietitian every two years. A nutritional profile is developed for each resident on admission which identifies dietary requirements and likes and dislikes, and this is provided to the kitchen staff by registered nurses. The kitchen is able to meet the needs of residents who require special diets, and the cooks work closely with the registered nurses on duty. Special diets and likes and dislikes are readily visible on a whiteboard in the kitchen and are updated with any changes to match updated nutritional profiles. Special equipment such as lipped plates and adapted cutlery are available according to resident need. On the day of audit, meals were observed to be well</p>

service delivery.		<p>presented. Supplements are provided to residents with identified weight loss issues. Additional snacks are available at all times.</p> <p>The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring February 2022. Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing. End-cooked and serving temperatures are taken on each meal. Chiller and freezer temperatures are taken daily and were all within the acceptable range. Cleaning schedules are maintained. All foods were date labelled in the pantry, chiller and freezer. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Resident meetings, surveys and interaction with the kitchen staff allow for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Assessments include falls, pressure area risk, skin integrity, nutritional, continence, pain (verbalising and non-verbalising), activities and cultural assessment. These are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time.</p> <p>InterRAI assessments had been completed for all long-term residents' files reviewed. Areas triggered were addressed in the care plans reviewed. Initial interRAI assessments and reviews are evident in printed format in all resident files (link 1.3.3.3).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery</p>	FA	<p>Five resident files were reviewed across a range of conditions including (but not limited to) pressure injury care, diabetes, dementia, behaviour that challenges, mobility, and weight loss. In all files reviewed the care plans were comprehensive, addressed the resident need and were integrated with other allied health</p>

<p>plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>services involved in resident care. Files reviewed identified input from a range of specialist care professionals, including the podiatrist, dietitian, wound care specialist and mental health care team for older people. Noting GP notes were not integrated in files (link 1.2.9.10). Relatives and residents interviewed all stated they were involved in the planning of resident care. In all files reviewed there is evidence of resident and relative involvement in care planning. Activity assessments were completed by the activities staff within three weeks of admission. Care plans reviewed provided evidence of individualised support. Short-term care plans are in use for short-term needs and changes in health status. The care staff interviewed advised that the care plans were easy to follow. Monitoring documents reviewed were well managed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The registered nurses complete care plans for residents. Progress notes in all files reviewed reflected the interventions detailed in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative's health status, and this was confirmed by family members interviewed, who stated they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of family/whānau contact for any changes to resident health status was viewed in the resident files sampled. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. A physiotherapist is employed to assess and assist residents' mobility and transfer needs.</p> <p>Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and documented wound progress. There were seven ongoing wounds including one lesion, three skin tears, two grade 2 pressure injuries (facility acquired) and one unstageable pressure injury (facility acquired). There was evidence of wound nurse specialist involvement when required for advice and input.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.</p> <p>Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring. Overall, monitoring requirements were documented with the exception of neurological observations which were not always completed as per policy (link 1.2.4.3).</p> <p>The GP interviewed was complimentary of the service and care provided.</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 service employs a diversional therapist and utilises volunteer activity assistants to plan and lead activities in the home. A weekly activities calendar incorporates set themes and events to which the activities team add to in order to individualise activities to resident need and preferences within the facility. A weekly activities calendar is distributed to residents, posted on noticeboards and is available in large print. On the days of audit residents were observed participating in activities. The diversional therapist seeks verbal feedback on activities from residents and families to evaluate the effectiveness of the activity programme, enabling further adaptation if required. Residents interviewed were positive about the activity programme.</p> <p>Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. There are weekly outings to places of interest in the community and there are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and other cultural festive days are celebrated. There are visiting community groups such as the kapa haka, church groups and ukulele group. The activity team provide a range of activities which include (but are not limited to) exercises, bowls, crafts, games, quizzes, entertainers, and bingo.</p> <p>The diversional therapist is involved in the admission process, completing the initial activities assessment, and has input into the cultural assessment, adding additional information as appropriate. An activities plan is completed within timeframes, a monthly record of attendance is maintained, and evaluations are completed six-monthly.</p> <p>Those residents who prefer to not to participate in communal activities receive one-on-one visits and individualised activities according to their preferences.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The five resident care plans reviewed had been evaluated by the registered nurses if there was a change in resident health status. Care plan evaluations were documented and reviewed progress to meeting goals (link 1.3.3.3). Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so. Six monthly multi-disciplinary reviews and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the diversional therapist, resident and family/whānau members and any other relevant person involved in the care of the resident. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	FA	<p>Whangaroa Health Services facilitates access to other medical and non-medical services. Referral to other health and disability services is evident in the sample group of resident files. The RNs initiate referrals to nurse specialists, and allied health services. Other specialist referrals are made by the GP. Referrals and</p>

<p>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>options for care were discussed with the family, as evidenced in medical notes. Referral documentation is maintained on resident files. The acting clinical manager interviewed gave an example of where a resident's condition had changed, and the resident had been reassessed for end-of-life care and a referral for hospice input had occurred. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>PA Low</p>	<p>There are policies and documented processes regarding chemical safety and waste disposal in place. All chemicals were clearly labelled with manufacturer's labels, however not all were stored in locked areas. Safety datasheets and product sheets are available and readily accessible for staff. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff and were seen to be worn by staff when carrying out their duties on the day of audit. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>The service did not display a current building warrant of fitness.</p> <p>The service employs two maintenance persons covering five days a week plus on call as required. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes six-monthly building compliance checks, (eg, hot water temperature, call bells, resident equipment and safety checks). Medical equipment has an annual calibration which is next due in December 2021. Electrical appliances have been tested and tagged and are next due to be tested in February 2022. Fire system compliance checks are carried out, however newly fitted smoke doors are not connected to the fire alarm – door release system. Essential contractors are available 24-hours.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and decking on the ground floor. There is a designated outdoor smoking area. Seating and shade are provided. The HCAs and RNs interviewed stated they have sufficient equipment to safely deliver cares as outlined in the resident care plans.</p> <p>Partial provisional: There are adequate numbers of hoists and mobility equipment available to allow for the safe transfer and mobility for residents. The GM confirmed that in the event additional hospital level residents required a hoist, the clinical manager would assess the need for additional equipment and that this</p>

		would be supported by the trust board.
<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 sufficient showers and toilets for the residents in all units. There are communal toilets located near the lounge/dining rooms. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Residents interviewed reported their privacy is maintained at all times.</p> <p>Partial Provisional: Visual inspection evidenced toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Handrails are appropriately placed in bathrooms, communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility equipment. Residents are encouraged to personalise their bedrooms with personal belongings as viewed on the day of audit. Staff interviewed reported that they have more than adequate space to provide care to residents.</p> <p>Partial Provisional: The seven rooms located in the rest home wing that were assessed as suitable for either rest home or hospital level of care are ample-sized, contain hospital level beds, and include extra wide doors to allow for equipment to move safely in and out of the rooms. They are located on same (ground) level and are adjacent to the current dual-purpose rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and</p>	FA	<p>There are large and small communal areas. Activities occur in all lounges and dining areas which are large enough to cater for the activities on offer, are accessible and can accommodate the equipment required for the residents. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The lounge and dining areas are spacious, inviting and appropriate for the needs of the residents. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance during the audit.</p> <p>Partial Provisional: The dining and lounge areas in the rest home wing can comfortably accommodate either</p>

dining needs.		rest home or hospital level residents.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All laundry is done on site. There are clearly defined clean and dirty areas and entry/exit.</p> <p>There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times when in use and stored in the sluice at other times (link 1.4.1.1). All chemicals on the cleaner's trolley were labelled. Residents and family interviewed reported satisfaction with the cleaning and laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency/disaster management plans in place to guide staff in managing emergencies and disasters. Emergency management is included in the mandatory in-service programme (link 1.2.7.5). Three of six RNs hold a current first aid certificate with the remaining three RNs scheduled to attend a first aid course (link 1.2.7.5). Fire evacuation drills take place every six months with the most recent drill taking place on 24 February 2021. There is an approved fire evacuation scheme. Fire walls are currently under construction (link 1.4.2.1). The service has alternative gas facilities for cooking in the event of a power failure, with a generator available for emergency lighting and battery backup. Adequate emergency water stores are available. Residents were observed with call bells in close proximity. There are two call bells systems being used that are regularly checked by maintenance staff. The facility is secured at sundown and is kept locked until the morning light.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas are appropriately heated and have ample natural light and ventilation. The facility has thermostatically controlled heating. Staff and residents interviewed stated that this is effective. All bedrooms and communal areas have at least one external window. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
Standard 3.1: Infection control management	FA	The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and

<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>		<p>reporting. The infection control nurse (ICN) is an RN who is responsible for infection control across the facility as detailed in the ICN job description (signed copy sighted on day of audit). The ICN oversees infection control for the facility, reviews incidents on HCSL and is responsible for the collation of monthly infection events and reports. The infection control committee and facility management are responsible for the development and review of the infection control programme. The programme has been reviewed annually.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There was one outbreak in 2021 which was appropriately managed.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene, donning/doffing and use of PPE.</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>There are adequate resources to implement the infection control programme at Whangaroa Health Services. The ICN liaises with the infection control committee who meet monthly and as required. Information is shared as part of staff meetings and also as part of the registered nurse meetings. The ICN has completed annual training in infection control. External resources and support are available through the local DHB, microbiologist, GP, and wound nurse when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the clinical manager.</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</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, the infection control team, and training and education of staff. Infection control procedures developed in respect of care, the kitchen, laundry and housekeeping incorporate the principles of infection control. Policies are updated regularly by an external contractor (HCSL).</p>

appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The ICN is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the in-services that are held for all staff, and staff have completed infection control education in the last 12 months. The infection control nurse has access to the internet-based education resources and guidelines for best practice. The ICN has also completed infection control audits.</p> <p>Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the organisation's surveillance policy. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified, and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the infection control meetings. Meeting minutes are available to staff.</p> <p>Infections are entered into the electronic database (HCSL) and corrective actions are established where trends are identified.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirms their understanding of restraints and enablers. At the time of the audit, the service had six (hospital level) residents using bed rails and a lap belt as restraints, and one (hospital level) resident with bedrails as an enabler. Staff training is available around restraint minimisation and management of challenging behaviours (link 1.2.7.5).</p>
<p>Standard 2.2.1: Restraint approval and processes</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) are documented and understood. The restraint coordinator was not available during the audit with the interim clinical manager responsible for the restraint programme in her absence.</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>The interim clinical manager has a sound understanding of the restraint minimisation programme.</p> <p>The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Ongoing consultation with the resident and family/whānau are evident. The files for two hospital level residents using bed rails and a lap belt as a restraint and one hospital level resident using bedrails as an enabler were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to trial (as appropriate) before restraint is used.</p> <p>The care plans reviewed of two residents with restraint, identified observations and monitoring, with monitoring records indicating it is occurring at the frequency determined in the restraint assessment.</p> <p>Restraint use is reviewed through the one-three-monthly evaluation process and six-monthly multidisciplinary meetings. A restraint register is in place, providing a record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred one-three-monthly as part of the ongoing reassessment for the residents on the restraint register. Evaluation timeframes are determined by risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality</p>	FA	<p>The restraint programme is regularly monitored for its effectiveness, led by the restraint coordinator. Efforts are currently underway to increase staff attendance at restraint minimisation education and training (link</p>

Review Services demonstrate the monitoring and quality review of their use of restraint.		1.2.7.5).
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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 in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	Health and safety meetings take place quarterly. A corrective action plan is in place for areas identified for improvements including the expired building warrant of fitness (link 1.4.2.1). New staff and contractors are orientated to health and safety practices. Health and safety audits, to monitor hazards, has not been undertaken for over one year.	The hazard register, and associated environmental audit, are overdue for monitoring and review with the last review taking place over one year ago.	<p>Ensure hazards are regularly monitored to ensure that hazards are either eliminated, isolated or minimised.</p> <p>90 days</p>

<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>Accidents and incidents were documented in a comprehensive manner, including actions to be taken to prevent recurrence. Family notification is also documented on the accident/incident form. Missing was consistent evidence of neurological observations being completed as per protocol.</p>	<p>Two of three unwitnessed falls with associated neurological observations did not follow the RN protocol.</p>	<p>Ensure all unwitnessed falls follow written protocol for neurological observations.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>An orientation programme is in place for new staff, relevant to their job role and responsibilities. Missing is documentation to evidence that the orientation programme is completed.</p>	<p>Three of six staff files were missing evidence of a completed orientation programme.</p>	<p>Ensure documentation is held to evidence staff completing an orientation programme.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>Staff have attended less than eight hours per annum of education per year. They have implemented an online training programme, but the staff (interviewed) stated that they are not confident with computers and just don't do the required training on the computers. The chief executive acknowledges this problem and states that he plans to go back to delivering more in-service training to try to increase staff numbers.</p>	<p>i) The auditor was unable to evidence that care staff have attended a minimum of eight hours of training over the past 12 months. Staff interviewed confirmed that they are reluctant to use the online education programme that has been made available to them.</p> <p>ii) Three of six RNs have evidence of</p>	<p>i) Ensure that staff attend a minimum of eight hours of training per year.</p> <p>ii) A person trained in first aid/CPR must be available 24/7 and on outings.</p>

			current first aid/CPR certificates which leaves the facility short of an individual with a current CPR certificate 24/7 and on outings.	60 days
<p>Criterion 1.2.9.10</p> <p>All records pertaining to individual consumer service delivery are integrated.</p>	<p>PA Moderate</p>	<p>Five resident files were reviewed. All had been reviewed at least three-monthly by the contracted GP. The GP notes from these reviews are not in the resident file and are held on a separate system to which the nurses have no independent access.</p>	<p>Four of five resident file reviewed did not contain medical notes from GP reviews.</p>	<p>Ensure all records pertaining to individual consumer service are integrated.</p> <p>60 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>All five resident files reviewed documented a care plan using the organisation's template. Long-term care plans and interRAI assessments were not reviewed/evaluated within the required timeframes.</p>	<p>Two of five resident files showed long-term care plans and interRAI assessments were not reviewed within the timeframes stated in policy.</p>	<p>Ensure all interRAI assessments and care plans are reviewed within the required timeframes according to policy.</p> <p>90 days</p>
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with</p>	<p>PA Low</p>	<p>The sluice contained chemicals that were not stored safely in a locked cupboard/room. A corrective action plan to remedy this was commenced</p>	<p>The new sluice doors did not have locks fitted on the day of audit. A cleaner's trolley containing cleaning</p>	<p>Ensure all chemicals are stored safely in a manner not accessible</p>

current legislation and territorial authority requirements.		on day of audit.	chemicals was readily accessible in the open, non-lockable sluice room.	to residents and visitors. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	The service displayed a BWOF that expired 31 May 2020. The newly fitted smoke doors are not connected to the current fire alarm – door release system.	(i). The service does not have a current BWOF. (ii). The smoke doors do not comply with the current fire service evacuation plan.	(i)-(ii). Ensure the building complies with current legislation. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.