

Heritage Lifecare Limited - Te Wiremu House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Te Wiremu House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 1 February 2022 End date: 2 February 2022
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	79

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Te Wiremu House provides rest home, hospital and dementia care for up to 85 residents. The service is operated by Heritage Lifecare Limited (HLL) and managed by a care home and village manager (CHVM) supported by a clinical services manager (CSM). There have been no significant changes to the service and facilities since the previous audit.

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, whānau, management, staff, a contracted nurse practitioner, and other contracted allied health providers.

This audit has resulted in two areas requiring improvement, both related to medication management. Residents and whānau interviewed spoke positively about the service and care provided.

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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The Code of Health and Disability Services Consumer Rights (the Code) is incorporated into the service's policies and procedures, and into everyday practice in the way care and support is provided. Residents who were interviewed advised that they are aware of their rights and can choose what they want to do. They confirmed that there is good communication from staff.


Residents are treated with dignity, respect, and understanding. Privacy is respected and ongoing family involvement is encouraged. Cultural and spiritual values, beliefs, and wishes are identified and supported. There is ongoing contact with the local health and disability service advocate.

Residents can participate in a range of activities, both within the service and in the wider community. They are supported and encouraged to be as independent as possible.

There was no evidence of abuse or neglect, or any discrimination, coercion, harassment, sexual, financial, or other exploitation. Residents and whānau interviewed spoke very positively about the care and support provided.

A complaints register is maintained with complaints resolved promptly and effectively. There is currently one Health and Disability Commissioner (HDC) complaint in progress.

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.		Standards applicable to this service fully attained.
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HLL is the governing body for Te Wiremu House and is responsible for the services provided. Business and quality and risk management plans include the goals and values of the organisation. Monitoring of the services is provided to HLL support office and this is regular and effective.

An experienced and suitably qualified CHVM manages the facility, supported by a CSM, with additional support from the regional quality manager. The CHVM is experienced in the management of an aged care facility having been in the post for 13 years. The

CSM is a registered nurse (RN) who is responsible for clinical management and oversight of care services. The CSM has been in the current role for 18 months but has had 15 years' experience as an RN at Te Wiremu House. The clinical manager is supported by a team of experienced RNs.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. The facility collects information to monitor key quality indicators, including complaints, and organisational performance. Staff are involved and feedback is sought from residents and whānau. Adverse events are documented with corrective actions implemented. Actual and potential risks, including hazards and health and safety risks, are identified, and mitigated. Policies and procedures support service delivery, they are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. Annual practising certification for those who require them to practice are current. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review.

Staffing levels are adequate across the service and the skill mix meets the changing needs of residents. RNs are on duty 24 hours per day, seven days per week. All RNs and some other staff have current first aid certification.

Resident information is held securely and meets all requirements of the standards.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Te Wiremu House policies and procedures provide documented guidelines for access and entry to service. All residents are assessed before entry to the service to confirm their level of care. The nursing team is responsible for all assessments, care planning, and evaluation of service delivery plans. Care plans are individualised and based on the residents' assessed needs and basic routines. Interventions developed are appropriate and evaluated within the recommended time frames. The ongoing evaluation process ensured that assessments reflected the residents' status.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activity plans were completed in consultation with nominated whānau and included residents' activities of interest. Residents and whānau expressed satisfaction with how activities are conducted at the service and the activities programme in place.

There is a medicine management system in place. All medications are reviewed by the general practitioner (GP) and nurse practitioners (NPs) every three months. Staff involved in medication administration have current medication competencies.

The food service provides for specific dietary likes and dislikes of the residents. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Te Wiremu House has systems in place to meet the needs of residents. It was clean and well maintained. There was a current building warrant of fitness. Electrical equipment and hot water temperatures are tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

Staff are trained in emergency procedures and the use of emergency equipment and supplies. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint policy documents enabler and restraint procedures. The policy contains a comprehensive assessment, approval, and monitoring process with a requirement for regular review. Use of enablers is voluntary for the safety of residents in response to individual requests. Three enablers and 11 restraints are in use at the time of audit. Staff are trained in restraint minimisation and challenging behaviour management and demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control management system minimises the risk of infection to residents, visitors, and other service providers. The infection control coordinator (ICC) is responsible for coordinating the education and training of staff. Infection data is collated monthly, analysed, and reported during staff meetings.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service and are carried out as specified in the infection control programme.

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	49	0	0	1	0	0
Criteria	0	99	0	0	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and the annual in-service education programme. For example, staff were observed knocking on residents' doors before entering their rooms, staff spoke to residents with respect and dignity, calling residents by their preferred names. Staff were observed on the days of the audit to demonstrate knowledge of the Code when interacting with residents. The last training on the Code was conducted during the service's 'toolbox talk' on 28 May 2021.</p> <p>The residents interviewed confirmed that they are treated with respect and understand their rights. The whānau reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled verified that informed consent had been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA), where applicable. All residents in the dementia wing had enacted EPOA. The GP makes a clinically based decision on resuscitation authorisation.</p> <p>There are guidelines in the policy for advance directives that meet legislative requirements. Advance directives and advance care plans are used to enable residents to choose and make decisions related to</p>

<p>choices and give informed consent.</p>		<p>end-of-life care. Some files reviewed had signed advance care plans that identify residents' wishes and meet legislative requirements.</p> <p>Staff were observed to gain consent for day-to-day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</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>As part of the admission process residents and their whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the nationwide advocacy service were displayed and available in the facility. Residents and whānau were aware of the advocacy service, how to access this, and their right to have support persons. The CSM and staff provided examples of the involvement of advocacy services concerning residents' care.</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 whānau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. All residents are assisted in accessing community resources and mainstream support. Whānau and friends are encouraged to visit or call.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' whānau and friends. Currently, all visiting/outings are strictly by appointment following all infection prevention and control protocols under the current COVID-19 restrictions. Whānau members interviewed stated they felt welcome when they visited and comfortable in their encounters 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 complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and whānau on admission and those interviewed knew how to make a complaint should they choose to do so.</p> <p>The complaints register reviewed showed that 35 complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the appropriate timeframe. Complaints related to service issues included food (21), the environment (four), resident care (nine), and treatment (one). Action plans showed any required follow up and improvements or corrections have been made. The CHVM is responsible for complaints management and follow up with support from the HLL support office.</p> <p>All staff interviewed confirmed an understanding of the complaint process and what actions are required.</p>

		There has also been one complaint received from the Office of the Health and Disability Commissioner relating to resident care. HLL and Te Wiremu House have responded to the complaint in writing (on 29 April 2021); the complaint remains open.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their whānau, as confirmed in an interview with the CSM. Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally during daily care. Education is held by the Nationwide Health and Disability Advocacy Service annually.</p> <p>Resident agreements signed by either the residents or enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board contract requirements.</p>
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>There is a policy and procedures regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms, and reporting requirements. Staff respect and allow residents to express their personal, gender, sexual, cultural, religious, and spiritual identity. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There was one documented incident of abuse reported and this was managed according to policy (refer standard 1.2.4). Whānau and residents interviewed expressed no concerns regarding neglect or culturally unsafe practice.</p> <p>Residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values, and beliefs had been identified, documented, and incorporated into their care plan. There is a contracted physiotherapist who visits the service once a week.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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	FA	Te Wiremu House acknowledges its responsibility in its current operations to Māori residents. The CSM confirmed that the service responds in accordance with the Treaty of Waitangi taking into consideration the Māori Health Strategy and the Māori Health Plan. Assessments and care plans will document any cultural and spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. Cultural staff training is incorporated into the staff annual in-service education calendar. Twenty-nine residents identified as Māori and there are 45 staff members of Māori descent. Policies and procedures regarding the recognition of Māori values and beliefs are documented.

beliefs.		
<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>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner following protocols/guidelines as recognised by the resident and their whānau. Values and beliefs are discussed and incorporated into the care plan. Whānau and residents confirmed they were encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in the care plans reviewed.</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>Whānau interviewed stated that residents were free from any type of discrimination, harassment, or exploitation and that they felt safe. Residents interviewed reiterated the same. The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of conduct. A code of conduct statement is included in the staff employment agreement. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The CSM stated that there has been one incident of abuse reported and no episodes of neglect, nor discrimination towards residents.</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, diabetes nurse specialists, wound care specialists, mental health services for older persons, and education of staff. The NP confirmed the service sought prompt and appropriate medical intervention when required and was responsive to medical requests.</p> <p>Staff reported they receive management support to attend external education and access their professional networks to support contemporary good practice. There is specific training and education to assist the staff to manage residents safely. The care staff have either level two, three, or four New Zealand Qualification Authority certificates. The CSM and one of the senior RNs are currently enrolled in a community nurse prescribing programme which will enable them to prescribe certain medicines upon completion. Ten staff in the dementia unit had completed the required dementia training. The activities programme evidenced good practice for residents assessed as requiring all levels of care provided by the provider.</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>Whānau members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews This was supported in residents' records sampled. Staff understood the principles of open disclosure, which are supported by policies and procedures. Personal, health, and medical information are collected to facilitate the effective care of residents.</p> <p>The CSM reported that a variety of external resources, including support groups and interpreter/translation services, are accessed as required. The staff further reiterated that residents and relatives who are not conversant with the English language are advised of the availability of interpreter services at the first point of contact. There were no residents who required the services of an interpreter; however, the staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.</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>Te Wiremu House is part of the HLL group. The executive management team provide oversight and support to the facility. The business plan, which is reviewed annually, outlines the values and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans necessary to achieve them. A sample of monthly reports showed adequate information to monitor performance is reported including clinical quality indicators, complaints, incidents/accidents, hazards, financial performance, emerging risks and issues (eg, infection control and pandemic planning).</p> <p>The service is managed by a CHVM who holds relevant qualifications and has been in the role for 13 years. The CSM is responsible for oversight of clinical matters. The CSM has worked at Te Wiremu House for 15 years, the last 18 months as the CSM. The regional manager supports facility management. The CHVM and CSM maintain knowledge of the sector, regulatory and reporting requirements and maintain currency through regional meetings and engagement with the Tairāwhiti District Health Board (TDHB).</p> <p>The service holds contracts with the TDHB for aged-related residential care (ARRC), long-term chronic health conditions (under 65), dementia care (D3), respite, and dementia day care. On the day of audit there were 79 residents; 63 residents were receiving services under the ARRC contract, 14 under the dementia care contract, and two respite (hospital level care).</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>When the CHVM is absent, the CSM carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by an experienced senior RN who can take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</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>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and accidents, hazards, internal audit activities, complaints, a regular resident/whānau and staff satisfaction survey, and monitoring of outcomes of clinical issues including falls, infections, restraint and enabler use, pressure injury, wounds, and any health and safety issues (such as staff incidents). The facility has a health and safety representative who has undergone the required training to manage health and safety representation within the facility.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff, RN, and quality meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Some staff interviewed said that they did not feel they had input into quality and risk management activities though others said that they did. Review of the staff, RN, and quality meetings showed that staff were able to provide feedback in those forums if they wished.</p> <p>Resident/whānau satisfaction surveys are completed annually, the most recent one in 2021. The results from this survey showed the respondents were primarily positive about the service with most respondents scoring the service as “satisfied” or “very satisfied”. Results from the survey were benchmarked across all HLL sites. The ‘Net Promoter Score’ for Te Wiremu House was positive at 39 (benchmark expectation 20). A staff satisfaction survey from 2019 was also positive, results showing that staff were positive or very positive across nearly all criteria, particularly for engagement, values, leadership, and reduced work risk.</p> <p>Policies and procedures cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. Policies and procedures are distributed for staff who sign to indicate that they have read and understood the documents.</p> <p>Both the CHVM and CSM described the processes for the identification, monitoring, review and reporting of risks, and development of mitigation strategies. The CHVM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and</p>

<p>Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>actions followed-up in a timely manner. Adverse event data is collated, analysed, reported to HLL support office, and benchmarked across other facilities within the group. Whānau interviews supported that any untoward events were disclosed to them in an open and honest manner.</p> <p>Both the CHVM and the CSM described essential notification reporting requirements, including for pressure injuries. There have been 56 notifications of a significant event made to the Ministry of Health since the previous audit. Of these 24 related to resident behaviour, 11 for service interruption (including the 2021 earthquake and tsunami), nine for resident falls with injury, five for pressure injuries stage 3 or above, two for resident absconding, and one each for outbreak reporting (suspected respiratory syncytial virus (RSV) – not confirmed), theft, medication error, staff abuse of a resident and a stranger loitering on the property. The suspected RSV outbreak was reported to public health.</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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, and validation of qualifications and practising certificates (APCs), where required. There is a process in place to collect details of COVID-19 vaccination status and all staff are vaccinated. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on a biannual basis, including mandatory training requirements. Care staff working in the dementia care area have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. An external education programme that meets NZQA qualification is available to all caregiving staff. The CSM is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	FA	<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 and the RNs on duty can extend short-shift hours based on resident acuity within their shift. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.</p>

<p>and/or experienced service providers.</p>		<p>Care staff reported that they felt that staffing was insufficient to complete the work allocated to them. Residents and whānau interviewed reported that the staff were rushed at times. Observations of staff and resident movement on the days of audit showed that staff seemed to be moving in an unhurried manner and residents were up with completed cares within a reasonable timeframe. Review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. The CHVM confirmed that the roster was covered for care and registered staff, but this required staff picking up extra shifts at times and cover from casual staff which was felt not to be ideal in the longer term. There are four vacancies for caregiving staff and three for RNs which are proving difficult to fill at the current time. The roster allows for 15 staff for a morning shift (three of which are RNs), ten staff on an afternoon shift (one of which is an RN and another a team leader), and five staff on night duty (one of whom is an RN). The CHVM reported that the afternoon RN cover will be augmented with a further RN staff member once an RN recruit has been sourced.</p> <p>At least one staff member on duty has a current first aid certificate (all RNs, nine caregivers, one cleaner, and two maintenance people are first aid certified) and there is 24 hour/seven days a week (24/7) RN coverage for hospital residents.</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>FA</p>	<p>A resident register of all current and past residents is maintained. Resident individual information is kept electronically, and paper based. The resident's name, date of birth, and National Health Index (NHI) number are used 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.</p> <p>Records of inquiries that are declined are maintained in a paper record. There was evidence that unsuccessful inquiries are referred to their referrer for alternative providers that may suit their needs.</p> <p>Clinical notes were current and integrated with GP/NPs and allied health service provider notes.</p> <p>Archived paper records are held securely on-site and are readily retrievable using a cataloguing system. The electronic records are backed up in the 'Cloud-based' system. Residents' files are held for the required period before being destroyed.</p> <p>No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent,</p>	<p>FA</p>	<p>The entry to service policy includes all the required aspects of the management of inquiries and entry. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the whānau members of choice where appropriate, local communities, and referral agencies. Completed Needs Assessment and Service Coordination (NASC)</p>

<p>equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>authorisation forms for the dementia unit, rest home, and hospital level of care residents were sighted.</p> <p>Residents in the dementia unit were admitted with consent from EPOAs and documents sighted verified that EPOAs consented to referrals to specialist services. Files sampled evidenced that all residents were assessed by specialists and confirmed the current level of care.</p> <p>Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. Whānau interviewed confirmed that they received sufficient information regarding the services provided.</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>	<p>FA</p>	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Indications for use are noted for 'as required' medications, allergies are indicated, and photos were current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. The medication and associated documentation are in place. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from the hospital or any external appointments. The RNs check medicines against the prescription and these were updated on the pharmacy delivery forms. The GP/NPs complete three monthly reviews.</p> <p>There were no expired or unwanted medicines and expired medicines are returned to the pharmacy promptly. Medications were stored safely and securely in the trollies and locked storerooms. Medication competencies were completed annually for all staff administering medication. The CSM reported that some medication-related audits are conducted.</p> <p>The resident who was self-administering medication had a self-medication competency that was not reviewed in a timely manner.</p> <p>15 medication charts sampled evidenced inconsistent evaluation of the effectiveness of pro re nata (PRN) medicines administered. This included PRN medication prescribed for pain, sleeping, behavioural issues and elimination.</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>	FA	<p>The kitchen service complies with current food safety legislation and guidelines. The food service is managed by a chef who works Monday to Friday and the cook who covers weekends, all assisted by kitchen hands. There is an approved food control plan for the service which expires 18 September 2022. Meal services are prepared on-site and served in the respective dining areas. The menu was reviewed by the registered dietitian on 3 December 2021. The kitchen staff had current food handling certificates.</p> <p>Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents' weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night when required.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers are maintained. Food is transported in a hot cart box to the respective dining areas.</p> <p>The residents and whānau interviewed indicated satisfaction with the food service.</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 CSM reported that all potential residents who are declined entry are recorded and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The person/whānau is referred to the referral agency to ensure they will be admitted to the appropriate service provider.</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>Residents have their level of care identified through the needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' care plans and interRAI are completed within three weeks, according to policy. Assessments and care plans are detailed and included input from the resident and their whānau, and other health team members as appropriate. Additional assessments were completed according to the need (eg, behavioural, nutritional, continence, and skin and pressure risk assessments). The nursing team utilises standardised risk assessment tools on admission. In interviews conducted, whānau and residents expressed satisfaction with the assessment</p>

		process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The assessment findings and input from resident and/or whānau informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident-focused and individualised. Short-term care plans were used for short-term needs. Residents in the dementia unit had twenty-four-hour behaviour care plans in place. Behaviour management plans were implemented as required. Whānau and residents confirmed they were involved in the care planning process.</p> <p>Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapists, district nurses, dietitians, GP, and NPs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders were carried out. The CSM reported that the GP/NPs medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person-centred. This was further confirmed by the NP during the interview. Care staff confirmed that care was provided as outlined in the care plan.</p> <p>A range of equipment and resources are available, suited to the levels of care provided and in accordance with the residents' needs.</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>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by the DT and an activities coordinator assistant. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. The chaplain, hairdresser, and physiotherapist are on-site weekly. A resident's social profile is completed for each resident within two weeks of admission in consultation with the family. The activities staff formulate the activity programme. The activities are varied and appropriate for people living with dementia, rest home, hospital level of care, and those under 65 years of age. Residents' activities care plans were evaluated in a timely manner.</p> <p>Twenty-four-hour behaviour care plans reflected residents' preferred activities of choice and were evaluated every six months or as necessary. Activity progress notes and activity attendance checklists are completed daily. The residents were observed participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular</p>

		outings/drives, for all residents (as appropriate). Whānau members reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is documented on each shift by care staff in the progress notes. All noted changes by the health care assistants are reported to the nursing team in a timely manner. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals, occur every six months or sooner if residents' needs change. The evaluations are carried out by the RNs in conjunction with whānau, residents, GP/NPs, and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan. Short-term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and whānau are included and informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents and whānau are supported to access or seek a referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP/NPs and the nursing team refer to specialist service providers and the DHB. Referrals are followed up regularly by the GP/NPs and nursing team. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to, and the resident is transferred to the public hospital in an ambulance if required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed as necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Domestic, kitchen and care staff have access to chemical training and management of chemicals. Material safety data sheets (MSDS) were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Chemicals are correctly labelled and stored securely. There is provision and availability of a significant amount of personal protective clothing and equipment. Staff were observed using this.

delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 6 July 2022) is publicly displayed. All legislative requirements were met.</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, monitoring of hot water temperatures, and calibration of biomedical equipment is current as confirmed in documentation reviewed, interviews with the CHVM and maintenance person, and observation of the environment.</p> <p>The environment was hazard free and residents and staff were safe. Corridors are wide enough to accommodate residents, staff, and any equipment. Independence of residents is promoted at every opportunity. External areas are maintained and are appropriate to the resident groups and setting. The dementia unit garden area is secure. Where residents are transported in the facility vehicle, there are policies and procedures in place to minimise risk.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required, and any requests are appropriately actioned. Residents and whānau interviewed reported that they are happy with the environment but noted that it is dated (refer Standard 1.4.5).</p> <p>Resident and staff smoking/vaping is permitted at Te Wiremu House. This takes place in designated open spaces outside of the facility, away from windows and doors, and meets the requirements of the Smokefree Environments and Regulated Products Act 1990.</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. Within the facility there are 14 rooms with full ensuites and 39 with a toilet. The remainder use shared facilities. Shared facilities have 'engaged' indicators on the doors. All rooms have a handbasin available within the room. There is easy access to toilet facilities from communal areas. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. There are separate toilet facilities for staff and visitors.</p> <p>Residents and whānau report that there are sufficient toilets and showers. Auditors observed residents being supported to access toilets and showers in ways that showed respect and maintenance of dignity.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with</p>	FA	<p>There is adequate personal space in all the bedrooms to allow residents and staff to safely move around in the room. All bedrooms, except one which is a double, provide single accommodation and there was sufficient space in hospital level rooms for both the equipment, such as hoists or wheelchairs, and at least</p>

adequate personal space/bed areas appropriate to the consumer group and setting.		<p>two staff and the resident. The residents sharing the double room requested that they be permitted to share. Rooms are personalised with furnishings, photos, and other personal possessions. Residents are encouraged to make the room their own and staff and residents reported the adequacy of room space.</p> <p>There is room to store wheelchairs and mobility aids (including scooters) within the facility.</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>Communal areas are available for residents to engage in dining and social activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Visitors and residents, including younger people (YPD), are able to access areas for privacy as required. Furniture is appropriate to the setting and arranged in a manner which allows residents to mobilise freely.</p> <p>A refurbishment plan is in place for Te Wiremu House to upgrade the corridors and communal areas of the facility with painting, wallpaper, repair of woodwork, and carpeting (refer 1.4.2). The work is due to begin within the next few months (depending on any COVID-19 restrictions and contractor availability).</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry services are completed on site. The laundry is operated seven days per week. There are designated clean and dirty areas in the laundry with separate doors to take clean and dirty laundry in and out. Laundry staff return linen to residents' rooms. The linen trolleys have baskets that are clearly labelled to identify resident's individual laundry and general laundry. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners and laundry staff have lockable cupboards for chemicals and the cleaners are aware that the cleaning trolley must be with them at all times. Cleaners were observed on the days of the audit keeping the cleaning trolley in sight.</p> <p>All chemicals are in appropriately labelled containers. Laundry and cleaning staff were aware of what they needed to do in an emergency and how to access material data safety sheets (MDSS). Laundry chemicals are administered through a closed system which is managed by a chemical contractor company who also educates laundry and cleaning staff on chemical safety.</p> <p>Residents and whānau stated they were satisfied with the cleaning and laundry services and reported that laundry was returned in a timely manner. Cleaning and laundry processes are monitored through the internal audit programme.</p>
Standard 1.4.7: Essential, Emergency, And Security	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>described 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 30 May 2016. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 23 September 2021. The Te Wiremu House fire and emergency plan was approved by the Tairāwhiti District Health Board as meeting contract requirements on 23 December 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 food, blankets, torches, mobile phones, and gas barbecues were sighted and meet the requirements of residents. There is a generator on site and potable water storage tanks (30,000 litres) which are located outside the facility. Emergency lighting is regularly tested. Staff records sampled provided evidence of current training regarding fire, emergency, and security education.</p> <p>The service has a call bell system in place that is used by the residents, whānau and staff members to summon assistance. All residents have access to a call bell, and these are checked monthly by the maintenance person. Residents and whānau confirmed that staff respond to calls in a timely manner.</p> <p>Appropriate security arrangements are in place. Doors are locked at a predetermined time and there is a closed-circuit television and video (CCTV) system monitoring the front of the facility, including the car park, for added security. Whānau and residents know the process of alerting staff when in need of access to the facility after hours.</p> <p>There is a visitors' policy and guidelines available to ensure resident safety and wellbeing is not compromised by visitors to the service. Visitors and contractors are required to sign in and out of visitors' registers, wear masks within the facility and complete a COVID-19 screening questionnaire and temperature monitoring. Contact information is collected for tracing should this be required.</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>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. There is access to outside garden spaces from communal areas with external doors that can be opened during the summer months to reduce heat within the facility and for air flow. Heating is provided through gas fuelled radiators with heat pumps in some areas. Areas were warm and well ventilated throughout the audit and residents and whānau confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p>	<p>FA</p>	<p>Te Wiremu House has a documented infection prevention and control programme that is reviewed annually. The review of the programme is completed by the RN who is the ICC in consultation with the</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>		<p>CSM. A position description for the ICC was in place.</p> <p>The service has guidelines in place to manage and prevent exposure to infections. Infection prevention and control training is provided to staff, residents, and visitors. There were adequate supplies of personal protective equipment (PPE) and hand sanitisers in stock. Hand washing audits were completed as per schedule. Policies and procedures are documented and reviewed regularly. Staff are advised not to attend work if they are unwell or self-isolate and get tested if they have been in contact with a person who has tested positive for COVID-19. Most residents and all staff were vaccinated for COVID-19 and influenza - completed records were sighted in all files sampled.</p> <p>There was a pandemic outbreak plan in place. Information and resources to support staff in managing COVID-19 were regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by the MOH were documented. There was a suspected respiratory syncytial virus (RSV) infection outbreak in July 2021 which was managed according to policy. There were no confirmed positive cases documented. An outbreak review document was produced to guide staff in managing the residents. The facility was closed to the public and this coincided with the COVID-19 national lockdown with GP, whānau, residents, and relevant authorities notified promptly. Documented evidence of staff and residents affected was sighted.</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 is a designated person who is responsible for implementing the infection control programme. The ICC indicated there are adequate people, physical, and information resources to implement the programme. Infection control reports are completed monthly, and these are discussed at management and staff meetings. Staff confirmed that infections rates information is shared in a timely manner.</p> <p>The ICC has access to residents' infection control data collected within the organisation and reported that there are sufficient resources and systems to collect all the necessary information. Surveillance, internal audits, investigations, and corrective actions are completed as required.</p> <p>Specialist support can be accessed through the district health board, the medical laboratory, external consultants, and the attending GP/NPs.</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</p>	<p>FA</p>	<p>The service has documented policies and procedures in place that reflect current best practices. Policies and procedures are accessible and available for staff in all the nurses' stations. Staff were observed to be following the infection control policies and procedures. 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 and gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures.</p>

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>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>Staff training on infection prevention and control is provided on an ongoing basis (eg, during orientation, shifts handovers, staff meetings and in the annual in-service education programme). The in-service education is conducted by either the ICC, local laboratory, or other external consultants. Also, education is provided in form of 'toolbox' talks. Monthly infection audits were completed and evidence of this was sighted.</p> <p>The infection training includes handwashing procedures, donning and doffing protective equipment, and regular COVID-19 updates. Records of staff education were maintained. The RN completed an infection prevention and control training course provided by the organisation in January 2022.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance programme is defined and appropriate to the size and scope of the service. The ICC collects infection surveillance data, analyses trends, monitors, reviews, and where possible implements corrective action plans to prevent recurrences. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and management meetings. Evidence of completed infection control audits, monthly reports, and annual reports was sighted.</p> <p>All staff interviewed confirmed that they are informed of infection rates as they occur. The GP/NPs were informed on time when a resident had an infection and appropriate antibiotics were prescribed for all diagnosed infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</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 (RC) provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibility required.</p> <p>On the day of audit, 11 residents were using restraints and three residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of</p>

		<p>enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, restraint documentation reviewed, and from interviews with the restraint coordinator and other staff. Restraints in use are limited to bed rails and pelvic belts.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval group, made up of the RC, CSM, and other RNs, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, resident documentation, 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 whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or 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>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the RC's involvement. Input in the decision making from the resident's whānau/EPOA was documented in each case and whānau confirmed their involvement. The RC and RNs interviewed were able to describe the restraint process. The NP or the resident's GP is involved in the final decision on the safety of the use of the restraint. The assessment process identifies the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised, and the RC described how alternatives to restraints are discussed with staff and whānau (eg, the use of sensor mats and low beds). 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 all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month, and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient</p>

		<p>information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken with 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>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed after the first month of use and then evaluated every three months along with six monthly evaluations during care planning activities and interRAI reviews. Restraint is also reviewed and evaluated at the restraint approval group meetings. Whānau interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality, RN, and staff meetings, and to the HLL support office. Minutes of meeting reviewed confirmed this and included 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 NP, GP, staff, whānau and any allied health professionals (eg, physiotherapists). A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education, and processes are implemented if indicated. Data reviewed, minutes and interviews confirmed that the use of restraint is actively minimised within the facility.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>The RN and enrolled nurse (EN) were observed administering medications safely and correctly in the hospital and dementia wings respectively. The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted. Monitoring of the medicine fridge and room temperatures are conducted regularly and deviations from normal were reported and attended to promptly.</p> <p>PRN medicines administered to residents, such as pain relief, laxatives, sleeping tablets, and those for behavioural issues, were not being documented for effectiveness in the electronic medication management system nor residents' progress notes. This was evidenced in 15 out of 18 medication charts sampled. The CSM and other RNs interviewed reported that this was an area that needed to be improved on and that measures to address this would be implemented.</p>	<p>Outcomes of PRN medicines administered in 15 out of 18 medication charts sampled were not consistently documented.</p>	<p>Ensure administered PRN medicines are evaluated for effectiveness.</p> <p>90 days</p>

<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>There was one resident self-administering medications and medicines were stored appropriately in a locked cupboard. The resident confirmed that staff supply the medication packs in a timely manner and checks on every shift if they have taken their medications. These are marked as doses supplied in the electronic medication management system. The sighted competency for self-administering medicines was last reviewed on 9 August 2021. However, the organisation's policy on self-administering competency for residents states that competency is to be reviewed every three months.</p>	<p>One resident who was self-administering medicines did not have their competency reviewed in a timely manner as per the organisation's policy.</p>	<p>Provide evidence that self-medication administration procedures are completed as per the organisation's policy.</p> <p>90 days</p>
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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.