

# Elsdon Enterprises Limited - Annaliese Haven Rest Home

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Elsdon Enterprises Limited
<b>Premises audited:</b>	Annaliese Haven Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 28 April 2016    End date: 29 April 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	50

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Annaliese Haven Rest Home is certified to provide rest home level care for up to 63 residents. The facility is in Kaiapoi Canterbury and is owned by Elsdon Enterprises Limited. The configuration of the service is 20 rest home beds and 43 dementia care beds. On the day of this certification audit there were 50 residents. There was full occupancy in the rest home service and 30 residents in the two dementia wings.

This audit against the Health and Disability Services Standards and the provider's contract with the district health board, included observation of the environment, interviews with the management team and staff, review of documentation and interviews with residents and their families.

Fourteen areas have been identified as requiring improvement. These relate to: informed consent; GP registration, training and appraisals; first aid training; dementia care training; interRAI assessments and care plans; ongoing assessments; care plan documents; evaluation of care plans; medication reconciliation; the self-administration of medication system; kitchen service; safe food handling; accessible external areas; laundry bags; emergency supplies and an alternative energy source.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The Code of Health and Disability Services Consumers' Rights (the Code) was on display and brochures available. Residents and family members have received written and verbal information on the Code.

Staff demonstrated respect and dignity to the residents and encouraged them to make their own decisions and do what they could for themselves. Residents confirmed their privacy is respected. There is no evidence of abuse or neglect.

As per the organisation's Maori health plan, Maori residents have the opportunity to link with a local Maori service to strengthen the cultural support they receive. Family/whanau are involved and assist with this.

Wider cultural needs and preferences are being upheld. A range of denominations contribute to the religious needs of the residents and other spiritual needs are being identified and addressed through activities provided.

Open disclosure is occurring and there are open communication systems at all levels within the organisations. The organisation has access to interpreter services. Families are the key advocates for residents, although information on the nationwide advocacy service is available.

Informed consent and advance directive processes are described in policy documents and efforts to implement them are in place.

Families and friends of residents visit as they choose and visitors are always welcomed. Residents link with the community through outings, use of external community services and by services coming into the facility for healthcare or for entertainment purposes.

There is a complaints process that is understood by residents, family members and staff and meets the requirements of the Code. A current complaints register is maintained by the facility manager.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The organisation's quality risk management plan is current and documents the facility's purpose, values, scope, direction and goals. The facility manager is new to the role and requires additional training to manage the facility. The clinical services manager has the relevant experience for her role and provides clinical oversight. In a temporary absence of the facility manager, the clinical services manager takes over day to day management of the facility.

There is a defined document control system in place. A suite of policies and procedures are current and reviewed regularly. An electronic risk system records accidents and incidents and these are analysed. An internal audit programme is maintained to ensure that required standards are being upheld. Corrective action plans are in place for system shortfalls.

There are appropriate systems for the recruitment, appointment and management of all employees including a comprehensive induction and orientation programme and the related documentation is completed. Employment practices meet best practice guidelines. Training and appraisal requirements are still to be fully implemented. A planned training programme guides professional development which is well supported by the organisation.

The roster indicates that staffing levels are safe, and that there is either the registered nurse or the clinical services manager on call for clinical issues. The facility manager is on call for non-clinical matters.

There is ongoing staff training and internal audits on managing clinical records. The clinical records that were reviewed meet requirements and they are stored securely. Residents' records are integrated.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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An information package about the service is available. Residents enter the service following a needs assessment that informs the level of service a person requires. Annaliese Haven provides rest home and dementia care services.

A range of assessments are undertaken prior to the development of care plans. The service is in transition from using one care plan format to another. Ongoing monitoring of a range of care and support issues, including weight management and behaviours, is occurring and reviews are being completed at three and six monthly intervals. Action is taken earlier if a person's condition changes.

There is a varied activities programme being implemented. This is generating positive feedback from residents and family members. Activities coordinators are maintaining assessment and recording documentation.

Referrals are being forwarded to relevant external healthcare services and/or support agencies.

Medicines are being administered as prescribed and according to organisational policies and procedures. Documentation around medicine management meets requirements, as does the storage of medicines. All staff who administer medicines are competent to do so.

The menu in use has been approved by a dietitian. New processes have been implemented for managing the kitchen but their implementation has been too recent for the effects to be seen.

## 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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The facility is a purpose built facility and is well maintained. Residents' rooms are kept clean, tidy, well ventilated and at a comfortable temperature. There are several communal areas which provide sufficient space for residents to use.

There are several external areas for residents to use, although not all have easy access. There are a sufficient toilets and bathrooms for the number of residents.

The building has a current building warrant of fitness.

There are systems in place for the management of waste and hazardous substances by staff who have been trained in this area.

Emergency procedures are well documented. Regular fire drills are held and staff are well trained to respond in any emergency.

Appropriate security arrangements are in place.

## 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 facility has a philosophy of not using restraints and there were no restraints or enablers in use at the time of the audit. There are policies and procedures in place, which meet the requirements of these standards, should they be needed. All staff receive training in the facility's procedures.

## 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 registered nurse is the clinical manager who has a defined role and time allocated to manage the environment and minimise the risk of infection to residents, staff and visitors. The service has a clearly defined and documented infection control programme that is reviewed at least annually.

Staff files, observation and interviews verify initial and ongoing infection control education occurs.

Surveillance for infection is conducted monthly and transferred to an electronic risk management system for analysis of trends and patterns.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	34	0	3	6	2	0
<b>Criteria</b>	0	79	0	8	4	2	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>An organisational policy specifically details the service's responsibilities around the Code of Health and Disability Services Consumers' Rights (the Code). Training on the Code has previously been provided and updates are pending. Staff demonstrated respect to the residents and to family members throughout the audit through the way they spoke with them, knocking on doors before entering and giving them choices and making suggestions rather than telling them what to do, for example. A family member informed that she felt the staff were aware of the rights of the residents and had never seen anything to the contrary.</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 choices and give informed consent.</p>	PA Low	<p>Policies and procedures regarding informed consent and advance directives were available. Informed consent is obtained on admission and signed informed consent forms were in residents' files. These cover a range of issues including the storage of personal information, use of photographs, authorisation to sign consent for medical and surgical intervention, transport, care and treatment based on assessed needs, their right to make choices and passing on information about their health and wellbeing. Prior to signing the informed consent form, staff are reportedly providing suitable information to the new resident and any family members present. Family members and residents who were interviewed are confident that they were given sufficient information prior to signing any forms. This includes written documents as well as verbal explanations. Not for resuscitation forms/advance directives are signed at the same time using the</p>

		<p>same process; however it was not possible to ascertain at what level any advance directive was being acted on. Other informed consent processes, such as influenza vaccinations, were also evident in residents' files.</p> <p>There are however areas in which the informed consent and advance directive processes are not currently meeting legislative requirements and these are in a combined corrective action.</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>	FA	<p>A registered nurse informs residents about their rights, including their right to an advocate when they are admitted. Residents spoken with were aware they could have such assistance with most stating that family members would be the people they would generally go to. A person without family stated they would use a 'mate'.</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>	FA	<p>There are open visiting opportunities throughout the day and evening. Family members and friend may come and go as they choose. This was observed during the audit. They are asked to sign into the visitors' book. Relatives are comfortable about the visiting arrangements and say they are always made to feel welcome. Residents confirmed they get visitors, that staff are good and always work around their visitors and that staff are happy for visitors to take them out even at short notice.</p> <p>Community links are strong with key local organisations contributing to the activities programme. Visiting health professionals, such as a podiatrist, diabetes nurse specialist and physiotherapist, have attended residents in recent weeks. In addition to outings with the activities coordinators, some residents go to local churches, out for walks, shopping or to the Returned Servicemen's Association.</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>	FA	<p>Annaliese Haven's complaints policy meets the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). This is provided to all new residents on entry to the service, and included at induction for all new staff. There is an annual staff training session that includes complaints management.</p> <p>The complaints register is maintained by the facility manager. There have been three complaints registered in the past year, two have been resolved and one is ongoing. The required timeframes have been met. For example written acknowledgement of the complaint has been provided within five days of receipt of the complaint, and every month if the issue has not been resolved. The issues raised were managed appropriately, and no specific trends are identified. Staff interviewed demonstrated a clear understanding of their responsibilities for reporting any concerns raised by residents and family.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information about the Code and the Nationwide Health and Disability Advocacy Service is provided to residents and any family members present, at the time of admission to the service. Staff reported that they make every effort to ensure a family member is present, especially when a new resident has dementia. A copy of the brochure on the Code is in the information package provided to residents when they enter the service. Most residents were able to confirm during interview that they know about the Code, albeit they did not know the details. All residents interviewed stated they are treated well and with respect.</p> <p>There was a copy of the Code with information about the advocacy services on it at the front entrance. Examples were provided of family members having acted as an advocate for a resident and the service provider informed that Aged Concern have also assisted in the past.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There is an organisational policy that refers to and outlines the requirements of the Privacy Act 1993 and Privacy Code 1994. The facility manager is the privacy officer. There is also a policy on spirituality that includes counselling for grief and bereavement, one on addressing cultural needs, one on sexuality and intimacy and one on abuse and neglect. Service providers were observed to be encouraging and supporting residents during the audit. Staff ensured residents' privacy by closing doors during personal cares, knocking and calling out before entering a bathroom, taking them aside to have a one on one conversation and by using their preferred name, for example.</p> <p>There was evidence that opportunities for residents to participate in spiritual/religious followings of their preference are provided. Likewise, people who identify with another culture are having this acknowledged and family support is encouraged. Staff from other cultures and ethnicities also offer additional support as appropriate.</p> <p>Residents and family members did not believe there would ever be an incident of abuse or neglect. They reported how good the staff are and said such a thing 'would never happen here'. People from Aged Concern have been used for advice and support and information about those services was available and was viewed. A reporting and investigation system is in place should any such allegation be made.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and</p>	FA	<p>A Maori Health Plan includes the definition of cultural safety for all. It encompasses the three principles of partnership, participation and protection and includes the Maori definitions appropriate to family/whanau inclusion; the four walls of Te Whare Tapa Wha and the process of total health in balancing the four walls.</p> <p>Issues relating to Maori in a health service are discussed and sacred practices that must be respected by</p>

<p>disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>the service are detailed. Cultural safety training for staff is scheduled to occur annually.</p> <p>An updated list of six Maori health providers who can provide assistance on request is listed. A person who identifies as Maori is receiving additional and regular cultural support from one such service. Family/whanau support is advocated and encouraged and this was confirmed from several sources.</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>	<p>FA</p>	<p>There were many examples of evidence that individual's culture, values and beliefs are being recognised and respected. Information about these needs is obtained from residents on entry to the service. These are documented in the residents' files that were reviewed.</p> <p>The service provider has association with most local religious denominations. On most weeks one denomination or another provides a joint dementia and rest home church service in the facility. One was held on one of the days of the audit. Staff are familiar with and respect the needs of a person of a less well known faith and assist at the level they can.</p> <p>The activities programme caters for people whose backgrounds are from other nations with Irish music and dance, for example. Staff also respect cultural elements of New Zealand. For example, they assist some residents to watch major rugby games in front of television in their pyjamas and provide pancakes and hot chocolate for breakfast.</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 Code of Conduct that is given to all new employees details expectations around professional boundaries. The clinical manager informed that staff are not retained if there is any evidence of this not being upheld and examples of how this had been managed were provided. None of the residents who were interviewed felt there had experienced any form of discrimination and only provided praise for staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There were examples of good practice that demonstrated leadership within the current management team to support staff to improve services for the residents. Examples included the use of a consultancy service to improve quality and risk management and practices around service delivery. Additional registered nurses have been employed and there is now one allocated to each of the wings in the dementia and rest home areas. Additional shifts have been added into the roster in response to an increase in resident acuity. An electronic risk management system is enabling faster identification of risk and facilitates mitigation or elimination of the risk.</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>The clinical manager has an open door policy for residents, family members and staff. Residents' meetings are held every two to three months. Family members informed that they can always approach the staff, or are approached by staff when they visit. They confirmed they are contacted when their relative becomes unwell or an adverse event occurs. There is evidence of family contact on all adverse event forms reviewed. Residents stated they are fully informed and if they do not understand what a staff person is saying the staff will willingly repeat it. They also noted that staff all seem to know what they are doing from one shift and one day to another.</p> <p>An interpreter policy is in place. Interpreter services provided a person with sign language expertise for a person with a hearing impairment when they were admitted and when they became unwell. There has been no other requirement for such a service, although examples of when family members and staff have assisted communication with a resident were provided.</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>Annaliese Haven is privately owned by a couple and their limited liability company is the governing body. The facility manager (FM) has been in her role for five months and provides organisational management oversight. While she has extensive management experience, this is the first time she has managed a residential care facility (refer criterion 1.2.7.2). She is supported by the clinical manager (CM) who provides clinical guidance. The organisation has recently engaged an external nurse consultant with vast residential care management experience to support the FM in her role. There has been a clear improvement in documentation and reporting since the engagement of the nurse consultant. There is evidence of reporting to the owners on a monthly basis and this is in line with the recently developed 2016 quality plan.</p> <p>The mission, vision and values of the organisation are documented in a business plan 2016 - 2018. These are reviewed annually against the organisation's objectives.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The FM and CM are interviewed. The CM assumes the role of FM during any temporary absences of the manager. A RN is available to cover the CM's absences. All RNs share the on call role, confirmed on the roster and during interview with the RN</p> <p>Staff during interview reported that the FM, CM RN are a supportive and stable team and that they are approachable and responsive to any queries they may have.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a documented and recently implemented 2016 quality and risk management plan that includes key components of service delivery. An internal audit programme is maintained to ensure that required standards are being upheld. This has recently been implemented so not all systems have yet been audited. Corrective action plans are in place for system shortfalls. Policies and procedures in place are current, regularly reviewed and reflect evidence based practices. The organisation has engaged an external nurse consultant to update policies and procedures specific to Annaliese Haven.</p> <p>The FM and CNM attend the monthly quality improvement meetings which includes all aspects of quality and risk. Minutes sighted confirmed that these are well attended by staff. The minutes included reports and discussion on resident's safety, pressure injury reporting, resident wellbeing, staff, education, hazards/risks, incidents and complaints, infection control, and maintenance. The meeting includes a summary of amended policies for implementation.</p> <p>Staff during interview confirm the improved processes in place and are kept informed of issues and trends at staff meetings.</p> <p>Quarterly residents' meetings occur and any issues here are carried over to the staff meeting. An internal audit programme is occurring. This covers 22 areas, including all aspects of service delivery. As this is a recent implementation results are not yet able to be reviewed.</p> <p>A recent resident satisfaction survey has been completed. The results have been analysed on the organisations electronic risk management system and a report generated to be included in the next quality meeting.</p> <p>An electronic risk management system records and analyses all risks. A sample of recent incidents (January to March) were included on the new system. A corrective action process is implemented for areas of non-compliance.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident and accident reporting policy which includes the essential notifications and statutory and regulatory reporting. The requirement to report pressure injuries of category 3 under section 31 of the Health and Disability Services (Safety) Act has been added to the policy.</p> <p>Adverse events are reported and recorded on an incident reporting form. The service has recently implemented an electronic risk reporting system that includes all adverse events for the current year January to March. A sample of ten incident report forms was reviewed. All have been analysed on an individual basis with no patterns or trends identified. Staff confirmed that they would report events using the reporting forms. They understand the importance of reporting events as soon as possible.</p> <p>As the electronic risk system is a recent implementation further analyses and implementation of action</p>

		<p>plans to address any areas where improvements could have been made, has not yet occurred.</p> <p>The FM provides a written report to the owners including an analysis of adverse events. The FM during interview was aware of the organisations responsibilities if a resident's level of care changes.</p> <p>The general practitioner (GP) reported that he is notified of events in a timely manner. Residents and family reported that they are also notified of events if they occur.</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>	PA Low	<p>The FM, with guidance from the CM, is responsible for human resources management. Professional registration was sighted and recorded in the RNs' files. One GP is noted on his registration certificate to be required to practice under supervision and this needs addressing to ensure this is occurring. The FM does have extensive management experience, but not in rest home management or the care of the older people, as required in the facility's service agreement D17.3d.</p> <p>A comprehensive induction and orientation programme is in place, including documented interviews, reference checks and police vetting of new staff. While there has been considerable progress in overdue staff performance appraisals, there are still about 10 that are outstanding and this requires improvement.</p> <p>The 2015 training programme includes monthly in-service education sessions. Content reflects service needs and standard requirements. First aid training and updates are part of ongoing professional development; however there is not always a staff member on each shift who has completed first aid training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The roster is reviewed and reflects the facility's skill mix policy. Care staff cover several shifts in all three wings over 24 hours. These exclude the registered nurses (RNs) who are separately assigned with often more than one RN on duty at the facility at any one time. This is reflective of the increased needs of the residents.</p> <p>The rostered hours meet the required standards.</p> <p>There has been two extra two hour shifts included across the week in the dementia wing roster to cover the more active times of the day when residents require extra support and care.</p> <p>Family, residents and staff interviewed confirm there are now sufficient stable staff to cover all shifts and this has improved over the past few months.</p> <p>There is evidence in the roster and skill mix sighted on the day of the audit that all previous issues raised have been addressed.</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>	FA	<p>Personal details of the resident and family members are entered into an electronic record system when the resident is admitted. Service delivery records are paper based. All pages have individualised stickers with key details of the resident attached to each page. All information is held securely with password protection for electronic records. Residents' files and other resident related documentation are held in nurses' stations that were locked when unoccupied. Overall records are legible with the designation of the writer alongside their signatures. Other than the electronic office based information, all residents' records are integrated.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Entry processes are described within organisational policies and procedures. All prospective residents require a needs assessment prior to entering the service and in the event of a person's condition changing. There is evidence that these are occurring and people are being transferred within the facility, or externally, if indicated by the needs assessment. Specific services provided at Annaliese Haven are for rest home and dementia services (rest home level). Families and prospective residents are given a list of appropriate options following the needs assessment. When approached for additional information Annaliese Haven provides a comprehensive information package about the service. A suitable time for the prospective resident and/or family member/s to view the facility is negotiated. Family and residents confirmed they visited prior to admission of the family visited the dementia service. Before sign-off of a new resident, a liaison process is undertaken between Annaliese Haven and Older Person's Health to ensure the service is a suitable option.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies and procedures in place for managing the death of a resident. There are also policies around transferring a resident, which may happen when a person requires a higher level of care than can be provided at Annaliese Haven. The clinical manager described how residents are re-assessed by the needs assessment service when such a situation arises and a recent example was given. The file of the person transferring is copied and goes with the resident. Annaliese Haven staff provide additional information on request after the transfer.</p> <p>A different transfer form is used when a person needs to go to the public hospital for care and treatment, whether or not a person will return to Annaliese Haven. Current medicines prescribed for the resident go with them.</p>
<p>Standard 1.3.12: Medicine</p>	PA High	<p>There are organisational policies and procedures on medicine management that meet requirements.</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>Medicines are being stored safely in a locked room. Medicines are being administered from blister packages that are placed on a lockable medicine trolleys during medicine administration rounds. An electronic system has been implemented for managing the medicines in both the rest home and dementia services. This is enabling safe practices around prescribing, dispensing, the recording of allergies, administration, review and recording systems. Unused medicines are taken to the pharmacy for disposal.</p> <p>All staff who administer medicines have a current medicine administration competency.</p> <p>The self-medication system is not operating according to the policy and procedure. A new recording system for self-medication has not yet been implemented, which is compromising the safety of the system.</p> <p>Recording systems are consistent with the requirements of the electronic system in use for managing medicines. During the observation of a medicine round staff were observed talking to residents about their medicines and answering questions. Practices around the administration of medicines were satisfactory.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>A rotating kitchen menu has been signed off by dietitians from the local district health board in November 2015, who have approved it for use in aged residential care facilities. This was a summer version and the cooks advised they do not yet have a winter version. Food is available 24 hours a day and includes sandwiches, fruit and biscuits.</p> <p>Residents and family members expressed satisfaction that the meals are suitable and that they do not have to eat items they do not like, which they just leave on their plate. On the day of audit, a cold meat was served to a person who did not like the main protein. Kitchen staff reported that they are aware of what residents like and prefer and which residents have special dietary requirements, or modified food consistency needs. There was no evidence to suggest that residents who have special dietary requirements are not having these met. There is however no system in place to ensure residents consistently have their food preferences and any special dietary requirements met.</p> <p>New systems have been developed to ensure that all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. These were provided to the kitchen on the day before the audit and have yet to be implemented. There were aspects of food storage, transport and delivery that require attention to ensure requirements are met, which the new system is expected to address.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	<p>FA</p>	<p>There are no records held of declining entry to this service. The clinical manager informed that she was not aware that any referral had ever been declined. An information booklet on the service clearly states the criteria for entry. All residents are required to have had a needs assessment prior to entering the</p>

<p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>service and it is not usual that people look at this service without these processes having been completed. Hence it is unlikely that a referral would be received, or the service suggested as an option for a prospective resident and/or family members, if they did not meet the criteria. There is a clause in the agreement, which describes the type of services provided at Annaliese Haven and that should a person's needs change then they would need to be transferred to a more suitable facility.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>A range of assessments, including full nursing assessments, pain, Coombes (falls risk); Braden (skin integrity) and mini nutritional are in use. Rest home residents interviewed confirmed that the staff asked them a lot of questions and did a lot of checks on them when they entered the service. They also stated that they are always checking on them.</p> <p>There has been difficulty accessing interRAI training for registered nurses, especially as many have only recently been employed, therefore there are less than a third of residents who have had an interRAI completed for assessment purposes. Behavioural assessment forms are in use in the residents' files that were reviewed. Although there was evidence that the information from assessment processes is being used to develop care plan interventions at a basic level, this needs further development.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA High</p>	<p>A new format has been introduced for nurses to use when developing care plans. When used correctly these will provide all staff with clear guidelines required for the services to be delivered to residents. Registered nurses are progressively transferring the information from the previous format to the new one. This process is creating some problems as a number of residents have some of their care plan in one format and some in another. There were examples of files in which the new blank formats had been placed into the files and the old version removed, thus leaving no care plan available. Information from interRAI has not been consistently used to guide the development of care plans, family have not been consistently invited to contribute and Te Whare Tapa Wha was not used for one person despite this being indicated. These issues require corrective action.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses and caregivers are responsible for the delivery of care and support for all residents. Two activities coordinators assist within their speciality areas. Residents, family members and others interviewed consistently reported that the needs of the residents are being met. Feedback was positive with all stating that their needs are being met and that medical intervention is being accessed when indicated. Despite the issues raised, the service delivery plans provide basic guidance to the staff who reported they have adequate information to meet the needs of the residents. The GP stated during interview that despite having only a few patients within this facility, he is confident instructions are carried</p>

		out according to his requests and that overall they are well cared for.
<p><b>Standard 1.3.7: Planned Activities</b></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 two activities coordinators at Annaliese Haven are currently undertaking training to become diversional therapists. They are currently using a local support network for mentoring type processes. An activities schedule is developed ahead of time and includes multi-faceted options of activities that cover cognitive, social, physical, coordination and communication skills. Outings and special interest topics such as gardening and crafts were also evident in the two that were sighted.</p> <p>Each resident had an activities assessment completed following their admission and a settling period. These were sighted in residents' files. Each detailed four to five goals, had a section for the anticipated benefits or outcomes, one on evaluation and one for the reviewer to sign and date. Activities plans in the dementia service covered 24 hours. However as previously noted only some of the 24 hour plans in the dementia service files were activity focused as the transition to change from the behaviour focused 24 hour plans is not yet complete. There were diversional therapy activity care plans to supplement these goal records and quality of life progress notes. All documents in each of the residents' care plans sighted were up to date and detailed with evidence of three monthly reviews occurring. As noted in 1.3.8.2, there is a need for the evaluations to reflect the level of attainment of the goals, rather than just be a progress report.</p> <p>All residents and family members interviewed were completely satisfied with the activities programme and openly described types of activities, outings and visiting singers and performers. Observations of different activities during the audit included performers, outings, newspaper reading, a church service and activities.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Moderate	<p>Registered nurses have made a significant effort to review all care plans over the last few months. All files reviewed during the audit had been formally reviewed by a registered nurse within the last three months in the dementia service and six months in the rest home area. There is a need for the reviews of personal goals in short and long term care plans and activity plans to be more reflective of the person's goals, for interRAI to be used at six monthly review timeframes and for short term care plan problems to be evaluated in an ongoing manner as long as the problem exists, rather than just closed out.</p> <p>There was good evidence in long term care plans that where changes have been identified through review processes or through progress recording that the care plan interventions had been changed accordingly.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are being referred to other health and/or disability providers. This is mostly done in conjunction with the GP. Examples on files that were reviewed included referrals to older person's health, psychiatric services for the elderly and dental services. Residents and family members are linked into the Alzheimer's Society and the Foundation for the Blind has recently also provided advice and assistance. A family member expressed gratitude on how the service had put them onto the Alzheimer's Society and useful they had found that. Residents' records include consultation and follow-up correspondence of referrals made.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are guidelines for the management of waste and hazardous substances, which are followed by staff. These include directions for housekeeping and laundry. Laundry is managed onsite and cleaning products are provided by an external contractor. This provider has material safety data sheets for all their products and these were current and matched all products used on site.</p> <p>All cleaning and laundry chemicals, and those used by the maintenance person, are stored in locked storage areas. Staff have access to cleaning chemicals in labelled containers with instructions for use.</p> <p>Staff have regular training in the use of the chemical products and in the management of waste and hazardous substances. This was evident in the review of personnel files and at interview with staff.</p> <p>Personal protective equipment (PPE) is available to all staff in utility rooms, the laundry and on the cleaner's trolley. Staff confirmed that they have ready access to adequate supplies of PPE at all times.</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 current building warrant of fitness expires 31 May 2016. Residents and family members interviewed during this audit reported that they find the environment is maintained to a very good standard at all times and it is well presented.</p> <p>The facility has had no building additions or reconfigured rooms since the previous audit.</p> <p>There is a regular system for the relevant testing, maintenance and calibration of electrical equipment and medical devices. This is maintained and current.</p> <p>Not all outside areas were easily accessed from the facility. All external areas are well maintained and provide an outside area for residents and visiting families to use.</p>
<p>Standard 1.4.3: Toilet, Shower,</p>	<p>FA</p>	<p>The facility has all single rooms. There are a combination of full ensuites and shared full ensuites for use</p>

<p>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>		<p>by residents. There are also additional communal shower and toilet facilities for residents in each wing. There is one additional toilet used for staff upstairs in the staff only area. A visitor's toilet and combination shower room identifies this is for visitors although it is observed residents using this.</p> <p>The ratio of toilets and bathing facilities are adequate given the guidelines for safe care which are utilised within the sector.</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>There are a range of room sizes in the facility. The smallest rooms meet the size requirements for the provision of rest home level care. Residents are able to move independently, or with the use of aids in their rooms. Residents have personal items and furniture in their rooms as they choose.</p> <p>All rooms are appropriate for the needs of the residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are several lounge areas and adjoining dining rooms in the dementia and rest home wings. The lounge and dining room are sufficiently spacious to accommodate residents and their family in private conversation as needed. There are several outdoor areas for those who choose to sit outside. Residents and family confirmed there are sufficient spaces for private conversations to occur.</p> <p>Residents and the family members reported their satisfaction with the environment at the facility.</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>	PA Low	<p>The laundry is managed onsite. A staff member during interview demonstrated processes that reflect the facility's policies and guidelines. Monitoring occurs through regular internal audits conducted by the clinical nurse manager (CNM). The cleaning and laundry products provider undertakes regular audits of the effectiveness of their products. Review of both confirms that the services are undertaken to an acceptable standard. The soiled linen laundry bags in the rest home were observed to be uncovered.</p> <p>Residents and a family member interviewed during the audit stated that they were satisfied with cleaning and laundry services. The facility is kept clean and is odour free. During the two days on site the environment was observed to be well maintained, clean and odour free. Chemicals and cleaning products were stored securely when not in use. All products were named with original labels.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>Staff members interviewed all confirmed that they receive training in fire, emergency and security procedures. This occurs at orientation and annually.</p> <p>There is a documented emergency plan, which covers processes for all emergencies. The FM and CNM were interviewed in relation to the emergency response preparedness for the facility. However not all systems are in place to respond to a significant civil defence emergency.</p> <p>There are security procedures in place to lock external doors and this occurs at 6.30 pm and are checked again during the night. According to the NZ fires service the approved evacuation plan for the facility remains current. The call bell system functions throughout the facility and was observed to be responded to in a timely manner.</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 rooms, including residents' bedrooms, have large windows, which allow natural light in. There are windows in every room, which can be opened to provide ventilation. On the days of audit it was cool and the facility felt comfortably warm.</p> <p>The rooms are maintained with good window coverings and a thermostatically controlled wall heater. Residents and family interviewed verify the facility is kept at a comfortable temperature all year round.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control (IC) RN is the CNM and was interviewed. The job description for the infection control coordinator role is clearly defined. There are clear lines of accountability for infection control matters at the service through the quality meetings. The FM attends these meetings. The IC coordinator provides a report to staff meetings on IC matters. A RN meeting covers any IC issues. The RN will provide IC training at ward level for identified issues.</p> <p>The annual review of the infection control programme has been conducted within the past 12 months.</p> <p>The service has clear policies about staff, residents and visitors suffering from, or exposed to and susceptible to, infectious diseases. Staff reported that they do not come to work if they are unwell.</p> <p>Notices are placed at entrances to ask visitors not to visit if they are unwell, or have been exposed to others who are unwell. There was sanitising hand gel throughout the facility for residents, visitors and staff.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The CNM attends ongoing education. The CNM reported that the facility can access external advice from the hospital IC consultant, the GP, DHB and Ministry of Health services as required. Infection control is discussed at the quality and RN meetings and staff education occurs on site in the ward area as IC topics as arise. An example is the recent focus on pressure injury prevention and care.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Annaliese Haven rest home uses policies and procedures that were developed by an external specialist consultant service and are current and reviewed annually. These have been designed to be fit for purpose for this service. Staff demonstrated good infection prevention and control practices reflective of policy.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control education is provided by the CNM who has maintained her knowledge of current practice. The in-service education programme contained education and attendance sheets for IC education sessions. These sessions were referenced to current accepted good practice. Infection control practices are included in induction and orientation for all new staff.</p> <p>Informal education is provided as required to residents and their family/whānau. The CNM gave examples of encouraging residents with fluids and personal hygiene for residents in the dementia wings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with</p>	FA	<p>The facility has clear lines of accountability for infection control matters through the quality meetings, and relevant information is provided to the FM at these meetings.</p> <p>A review of current infections (six) noted that all have been included on the electronic risk management</p>

<p>agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>system and an analysis identified no trends or patterns in these infections. The FM provides a written report to the owners including the analysis of infections.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>A documented restraint and enabler use policy is in place and meets the standard requirements. The facility would use enablers, such as bedrails, if required. At present there are no residents with either enablers or restraints in use at the facility. Staff interviewed demonstrated knowledge in enabler use and restraints and confirmed their training in relation to this. There is limited formal training in managing challenging behaviours in the facility including dementia (refer criterion 1.2.7.5)</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 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Low	<p>Informed consent forms are being completed when residents are admitted to the facility. Likewise, advance directives are being signed; however:</p> <ul style="list-style-type: none"> <li>- Signatures on 8 of 10 informed consent forms that were reviewed in the dementia service do not state whether they are a resident, a relative or a whanau representative and names of the signatories are not being printed on the form.</li> <li>- Relatives/EPOAs are signing 'not for resuscitation'/advance directive forms in the dementia service.</li> <li>- Paperwork confirming EPOA authority is not available for all residents in the dementia service and in two files two different family members had signed different parts of consent documentation on behalf of the resident(s).</li> <li>- A registered nurse, rather than a medical officer, has deemed a person was cognitively competent when their resuscitation form was signed.</li> </ul>	<p>The completion of most informed consent forms and advance directive in the dementia service do not meet legislative requirements. It is not always clear as to who has signed the form and in other cases the person signing the consent and/or the directive is not necessarily a person who can legally do so on behalf of that resident.</p>	<p>Where written consent and advance directives are required, the processes meet legislative requirements.</p> <p>90 days</p>

<p>Criterion 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>	<p>PA Low</p>	<p>Professional registration is sighted and current for all RNs, the pharmacist, podiatrist and eight general practitioners. One GP is noted to be under supervision.</p>	<p>The facility is engaging one GP to be their house doctor and he is currently seeing residents in the facility. It is noted on his registration that he is required to practice under supervision in the General Practice Education Programme. The certificate is valid to 31 May 2016.</p>	<p>Professional qualifications have evidence of registration and scope of practice to work within the rest home.</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 Low</p>	<p>A current education plan for 2016 has been implemented and well attended by staff. This included a session on the dementia person centred care. However, only one staff member in the dementia wing has the relevant dementia related training qualifications as required in the service agreement E4.5f. Records reviewed show that only two staff have this training.</p> <p>There are limited training records available for recent training in restraint minimisation and challenging behaviours. The CM during interview confirmed this has been planned for later in the year but will now be brought forward. The CM during interview reported that staff have completed training but these were not on site and with the previous training assessor.</p> <p>The FM has been in her role for four months. She does have a range of management experience, but not in residential aged care as required.</p> <p>The facility completes annual performance appraisals for all staff; however these are not all current. Ten staff are still to have annual appraisals completed.</p> <p>There is a comprehensive in service training programme that includes first aid training. A review of the current and previous roster of two weeks shows that not all shifts have a staff member with a current first aid certificate. In each week there</p>	<p>Not all staff in the dementia wing have the required training in supporting people with a dementia, or restraint minimisation and challenging behaviours.</p> <p>The FM does not have training specific to her role. Not all performance appraisals are up to date. Not all shifts have a staff member with a current first aid certificate.</p>	<p>All staff working in the dementia wing are required to complete dementia related qualifications, including restraint minimisation and challenging behaviours.</p> <p>The FM has training appropriate for her role in the rest home. Performance appraisals are completed annually for all staff. There is at least one staff member on all shifts with a current first aid certificate.</p> <p>90 days</p>

		are two shifts that do not have a staff member with a first aid certificate.		
<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>	PA High	<p>Medicine management is mostly occurring according to the organisation's medicine management policies and procedures. It is supported by an electronic medicine prescribing and recording system and safe storage practices. There are however some gaps in practice. For example, there is no documentation to evidence that a medicines reconciliation process is in place for blister packages arriving at the facility. In addition, there is a lack of accuracy and attention to detail around the system in place for medicines that require specific monitoring. For example, there was a short measurement evident for one significant medicine and some entries that require double signing only had one signature.</p>	<p>Not all aspects of medicine management meet the requirements of related legislation and authorised guidelines, especially around the reconciliation of medicines into the facility and monitoring medicines that require specific recording processes.</p>	<p>All aspects of medicine management meet the requirements of legislation and authorised guidelines, in particular those related to medicine reconciliation and the checking of medicines that require more intensive monitoring.</p> <p>30 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	<p>Residents have an opportunity to self-administer their own medicines. However, for one person their medicines were in two different places in their room, neither of which was lockable. A GP had signed that this person is competent to self-administer their medicines; however their self-medication competency had not been reviewed within the last three months, as is expected. A staff person signed off that a person had self-administered, however this was not checked. On the same day a staff person checked the medicine blister was empty but did not record the check in the system. Following investigation, it was found that a new recording system for self-medication is not yet in place, which is compromising the safety of self-medication processes. A shorter timeframe has been allocated to address this as although the risk is low, it is an</p>	<p>The self-medication system is not operating according to the policy and procedure as these medicines were not locked away and a resident's self-medication competency had not been reviewed within the last three months. A new recording system for self-medication is not yet in place, thus compromising the safety of the system as staff are not making and/or recording the required</p>	<p>Self-medication practices are safe and are implemented according to current organisational policies and procedures.</p> <p>30 days</p>

		issue that needs to be addressed promptly.	checks.	
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	PA Low	<p>Kitchen staff and support workers informed they are familiar with the needs of the residents regarding preferences for hot drinks, food likes and dislikes and any additional modified nutritional requirements or special diets of residents. Records relating to the nutritional needs of residents or their food preferences were not available in the kitchen. Some residents had completed nutritional assessments on file. A system to ensure these are made available to kitchen staff has not yet been implemented.</p>	<p>There is no system in place to ensure that residents who have additional or modified nutritional requirements, or special diets, will consistently have these needs met.</p>	<p>A system is implemented that enables certainty that residents who have additional or modified nutritional requirements or special diets will have these met in a consistent manner.</p> <p>90 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>A set of new documents around kitchen and food management were provided to the kitchen the day before to the audit and these were sighted. The new systems associated with these documents had not yet been implemented due to the timing.</p> <p>On the day of audit fridge and freezer temperatures are recorded on a daily basis. Leftover food is retained for 24 hours' maximum and food waste is disposed of in a general waste bag. All food is ordered according to the menu and is delivered to the facility. Kitchen staff store the food in the relevant area until due for use. Meals are prepared on site, placed in Bain Maries and delivered through to the relevant unit for support workers to serve. In the evening, the cook takes the temperatures of the hot food before she leaves, which is generally about two hours prior to the evening meal being served. There are aspects of these systems that do not meet the recommended guidelines for safe food handling. For example:</p> <ul style="list-style-type: none"> <li>- Actions have not been taken to address ongoing recordings of fridge and freezer temperatures that are outside</li> </ul>	<p>Not all practices within the kitchen comply with recommended safe food handling guidelines.</p>	<p>Ensure that all aspects of food storage, transport and delivery comply with current legislation and guidelines.</p> <p>90 days</p>

		<p>of what is considered to be a safe range.</p> <ul style="list-style-type: none"> <li>- The use by/expiry dates are not evident on food items such as decanted pantry goods.</li> <li>- Temperatures of hot meals are not being checked at the time of serving and temperatures of refrigerated foods such as meat and poultry are not being checked on arrival at the facility.</li> </ul>		
<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 Moderate</p>	<p>Not all residents have had an interRAI assessment completed while at Annaliese Haven. The registered nurse informed that approximately 12 have been completed within the dementia service to date; however these were not evident in the service delivery plans. Long term care plans have not all been completed within the required 21 days of admission and three short term problems had not had a short term care plan developed for them. Where short term care plans exist there is a lack of evidence of timely reviews of the interventions with the problem just being closed out and/or signed off in all examples sighted.</p>	<p>InterRAI assessments, the development of long term care plans and reviews of short term care plans have not all been completed within a timely manner to safely meet the needs of the consumers, as required by the standard and the aged residential care contract.</p>	<p>Each stage of service provision, especially the interRAI assessment, completion of long term care plans and the development and reviews of short term care plans are completed within the relevant and contractual timeframes to ensure the needs of residents are met safely.</p> <p>90 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are</p>	<p>PA Moderate</p>	<p>Information from initial assessments is not always being used to inform development of the care plan. Re-assessment processes have not been used to contribute to amend interventions in service delivery plans and interRAI is not being used as a standard tool to trigger residents' needs, as required by the ARC contract.</p> <p>Behaviour management assessment/recording forms are in place. These are not being completed as per the requirements</p>	<p>Not only is interRAI assessments not being used as per contractual requirements (as identified in 1.3.3 above) but current assessment and reassessment processes are not consistently being used to contribute to the</p>	<p>Assessment processes are consistently used to identify the needs, outcomes and/or goals of the residents and the information obtained is used to guide the</p>

documented to serve as the basis for service delivery planning.		of the form and nor are they being used to inform on ways of managing the behaviours either in the care plan, or for a behaviour management plan.	development of the care plan interventions. Behaviour management/assessment forms are not being used according to their purpose.	interventions in service delivery plans and in behavioural management plans.  90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA High	<p>New forms are being used for the format of service delivery plans and the transfer of information from previously used forms is underway. This transition process is presenting confusion; therefore, it cannot be guaranteed that residents will receive the desired outcome from their assessed needs.</p> <ul style="list-style-type: none"> <li>- One rest home file has had a previous version of their care plan archived and no current care plan was available in the resident's file. This problem was identified for a second resident not in the sample reviewed.</li> <li>- A second rest home resident had a partially completed care plan and the previous one removed. An intervention mentioned in progress notes was not evident in the sections completed thus far and the RN was not aware of it.</li> <li>- Only four of the 12 residents have had their information fully transferred into the new care plan format - the incomplete transfer of information into the new forms leaves residents at risk of not having their needs fully met.</li> <li>- In the sample reviewed, there were examples of two different sets of care plans in four residents' files from the dementia service (neither were archived). InterRAI triggers were absent in all (as identified in 1.3.3 above).</li> <li>- Although family are kept updated about residents' progress, there is limited evidence from family members interviewed, and in the care plans sighted, that family have been involved in the development of the care plan. The service has only recently commenced consistently involving family.</li> <li>- An organisational policy states the 'Te Whare Tapa</li> </ul>	There is no surety that residents will receive the support and care they require as there were at least two residents who did not have a care plan on file and the previous one could not be found. There were different care plan formats with incomplete versions on file for some residents. Family involvement is minimal and the Te Whare Tapa Wha model had not been used for the care plan for a person who identifies as Maori.	All residents have a current service delivery plan that describes the required support and/or intervention to achieve the desired outcomes, as identified in the triggers from an interRAI assessment. Te Whare Tapa Wha is used as the model for care when indicated and there is evidence of family involvement.  30 days

		Wha' model will be used as a basis for the care planning of a person who identifies as Maori. This was not evident in practise.		
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Moderate	<p>Reviews have been undertaken within the last three or six months in all files that were viewed. In the four files that have had the new care plan format adopted this was undertaken at the review timeframe and the previous plans were not sighted. The remaining eight files had reviews dated and signed. There are however some gaps in these processes as they lack an evaluative focus:</p> <p>The review section of these eight service delivery plans and activities plans are dated and signed, however they state 'no changes' or make a comment about the person. They do not report on the degree of achievement of the residents' goals. In activity plans, the evaluations are written when the plan is written and progress notes record the level of attainment of the activity goals.</p> <p>There is also a lack of consistency in the evaluation processes in the residents' files reviewed. For example, five had examples of specific assessment tools to contribute to the review having been used but others do not.</p> <p>As previously noted interRAI is not being used to contribute to the evaluation of residents' files.</p> <p>Goals, or interventions, for problems in short term care plans are not being evaluated. Some of the identified issues have just been 'closed' with no evaluative or review information, some remain open with no updates for many months and in two people's examples the issues were closed the day after the problem was identified, despite this being unrealistic.</p>	The evaluation processes for service delivery plans, including activity plans, do not consistently indicate the degree of achievement or response to the support and/or intervention and progress towards meeting the desired outcome/goal.	<p>Consistent processes are implemented for evaluation and review processes to ensure service delivery plans, including short term care plans, long term care plans and activity plans. These will indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcomes/goals.</p> <p>90 days</p>
Criterion 1.4.2.6 Consumers are	PA Low	Within the facility there are several areas where residents can access the external environment during the day. The dementia	Smoke free external areas available for residents in the	Residents in the dementia wing are

provided with safe and accessible external areas that meet their needs.		wing has access to several external areas, including an internal courtyard, although this area is the smoking area. These areas are secure during night time hours.	dementia service are routinely kept locked and only able to be accessed when a staff member uses their swipe key to allow external access. One staff member reported that he does open doors and clips them back when he is on duty between certain times of the day, but this is not a consistent practice.	provided with safe and accessible external areas that meet their needs.  90 days
Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Low	There are soiled linen bag trolleys for each area. In the dementia wing a fixed cover trolley is observed to be in place. A similar linen bag trolley is used in the rest home, but did not have a cover.	The soiled linen bag trolley in the rest home is not covered.	The rest homes soiled linen trolley is covered to ensure the safe storage of soiled laundry.  90 days
Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.	PA Moderate	There is a civil defence kit available with emergency supplies that are checked annually; however, other requirements needed during an emergency are not in place.	The facility does not have access to an alternative energy source in case of emergency. The FM reported that this was evident in a recent power outage when all the security doors were unlocked.  There is insufficient stored water available for all in case of an emergency.	Alternative energy and utility sources are available in the event of main supplies failing.  90 days

			Two emergency first aid kits are available; however, they do not include a list of contents or regular checks to ensure that supplies are intact.	
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.