

Glenhays Limited - Northanjer

Introduction

This report records the results of a Provisional 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: Glenhays Limited

Premises audited: Northanjer

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 28 February 2017 End date: 28 February 2017

Proposed changes to current services (if any): This rest home has been sold and the new owners are scheduled to take over management of this facility as from 22 May 2017.

Total beds occupied across all premises included in the audit on the first day of the audit: 15

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.

General overview of the audit

Northanjer is a 15 bed rest home in Oamaru, north Otago. This service has been owned and operated by a husband and wife team for 25 years and has strong links with another rest home in Oamaru. A provisional audit was undertaken in this service as it has been sold. Prospective owners are scheduled to take over from 22 May 2017. All fifteen beds were occupied on the day of audit.

The audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. Audit processes used included review of policies and procedures, reviews of residents' and staff files, observations and interviews with residents, family, management, staff and a general practitioner. An interview with the prospective provider was undertaken as part of the audit.

Continuous improvement has been acknowledged for the manner in which the care plans reflect the interRAI scores thus enabling accurate and measurable evaluation and review of residents' progress.

Consumer rights

Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff have received ongoing education on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).

There were no residents at the facility who identify as Maori. Services are planned to respect the individual culture, values and beliefs of all residents.

Residents, families and external health providers interviewed, stated that communication is excellent at this service. There was evidence that residents, families and other parties are provided with full and frank information in accordance with the principles of open disclosure. Appropriate written consents have been obtained.

A complaints process that meets requirements was in place. The nurse manager is responsible for the management of complaints and documents verbal as well as written complaints for quality improvement purposes. A complaint register that demonstrated complaints have been resolved promptly and effectively has been maintained.

Organisational management

A team of four form the governing body of the Northanjer rest home. This is shared with another facility in Oamaru called Southanjer rest home. All documentation and monitoring systems are shared between these two services. There is a business plan and a quality and risk management plan that include the scope, direction and goals of the organisation as well as values and a mission statement. Monitoring systems at governance and operational levels were in place.

The facility is managed by an experienced and suitably qualified registered nurse manager who reports monthly to the governing body.

A quality and risk management system includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction surveys. Collection, collation and analysis of quality improvement data is occurring and has been reported and discussed at monthly staff and six monthly general committee (quality) meetings. Adverse events are documented and seen as opportunities for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks have been identified and mitigated and the hazard register is up to date.

A suite of policies and procedures cover the necessary areas, are reviewed every two years and those sighted were current.

A human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. There is a comprehensive orientation and staff training programme that ensures staff are competent to undertake their role. A systematic approach to identify, plan, facilitate and record ongoing training was being instituted. Annual individual performance reviews were up to date.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. The roster demonstrates that every shift has a person with a current first aid certificate identified on it and informs who the out of hours on-call person is.

A resident information management system is in place and information is entered in a timely and accurate manner. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Continuum of service delivery

Entry criteria for the facility is documented and available for any person and referral agency. The owner / nurse manager discusses any prospective referral with the referral agency to ensure admission is appropriate. If entry to the service is declined, a record is maintained.

Residents receive timely and appropriate services in order to meet their assessed needs and desired outcome/goals. Each stage of service provision is undertaken by suitably qualified and experienced staff competent to perform the function.

The processes for assessment, planning, provision, review, and exit are provided within time frames that safely meet the needs of the resident and contractual requirements. The interRAI assessment tool has been fully implemented and the outcome scores included within the care planning process. Care plans are detailed and individualised, based on a comprehensive range of clinical information and the interRAI assessment. Short term care plans are developed to manage any problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a very high standard. Evaluation of care is consistently documented at least six monthly.

Residents are referred or transferred to other health services as required, with appropriate documented handovers.

The service provides an activities programme which reflects residents' preferences. The activities are planned and provided to develop and maintain skills and interests that are meaningful to the residents.

A medication management system is in place that meets all legislative and guideline requirements. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage.

The menu has been reviewed by a dietitian as suitable for the older person living in long term care. Residents and family reported a high level of satisfaction with the meals and choices provided.

Safe and appropriate environment

All types of waste and hazardous substances were being managed safely according to the principles and practices outlined in the policy and procedure documents. Staff have access to personal protective equipment and clothing.

The buildings and equipment comply with legislation, are being checked for safety and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme was being implemented.

Communal areas are homelike. Conservatories, plus shaded external areas with seating, are available.

Chemicals, soiled linen and equipment were safely stored. All laundry is undertaken onsite, with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills have been completed and a sprinkler system and smoke alarms are installed. A call bell system is operational.

Doors are locked at night and staff monitor the facility each hour. Windows have security latches and residents reported they feel safe.

All communal and resident areas have openable windows. It was a comfortable temperature inside the building.

Restraint minimisation and safe practice

Organisational policies and procedures support the minimisation of restraint. No restraints are used in this facility. Enablers are used for the safety of residents and in response to individual requests. One enabler was in use and appropriate documentation was in place. At orientation and every two years thereafter, staff receive training about all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

The nurse manager responsible for infection prevention and control has a defined role 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 verified initial and ongoing infection control education occurs.

Surveillance for infection is conducted monthly and annually and transferred to an annual data sheet. There is evidence of a continued reduction in infections and a proactive approach to continue this trend.

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) |
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| Standards | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 1 | 92 | 0 | 0 | 0 | 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 |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was displayed in the communal area in the facility. Residents and families reported that they were provided with copies of the Code as part of the admission process.</p> <p>Staff demonstrated knowledge of the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights.</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> | FA | <p>Files reviewed included appropriate written consents by the resident. Staff during interview demonstrated good knowledge of consent processes. Families and residents interviewed verified appropriate consents occur as part of everyday practice, and this was observed during the audit.</p> <p>There was evidence in files of Enduring Power of Attorney (EPOA) input for those who could not consent themselves.</p> |

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| <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>Residents and families interviewed reported that they were provided with information regarding access to advocacy services. Contact details for the Nationwide Health and Disability Advocacy Service was included in the admission package, with the brochure available at the entrance to the service. Education was conducted as part of the in-service education programme for staff. Staff demonstrated knowledge of advocacy processes.</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>Families reported that they are encouraged to visit at any time, and are always welcomed. Residents are supported and encouraged to access community services with visitors, or as part of the planned activities programme. There is evidence in residents' files that this occurs regularly. Staff were observed welcoming visitors and encouraging outings.</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>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information about the complaints process is provided to residents on admission and copies of complaint forms were available near the office. Residents interviewed were aware of their right to make a complaint, said they would just go to the manager if they were unhappy about something and expressed confidence the issues would be addressed.</p> <p>The complaints register reviewed showed that two complaints have been received over the past year. Follow up was well documented for both of these verbal complaints. The documentation demonstrated actions had been taken through to an agreed resolution, the responses were consistent with the timeframes specified in the Code and improvements had been made. The nurse manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> |

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| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>Families and residents interviewed reported that the Code was explained to them on admission, was included as part of the admission pack, and time was allowed for them to understand the information.</p> <p>The prospective provider during interview demonstrated knowledge and understanding of the Code and their need to adhere to these.</p> <p>Nationwide Health and Disability Advocacy service information is also included in the admission pack with brochures available at the entrance and hallway of the facility. Residents and families interviewed reported that they were aware of their right to access advocacy services but they had not needed to do so.</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> | <p>FA</p> | <p>Residents and families interviewed reported that the residents are treated in a manner that shows regard for the resident's dignity, privacy and independence. Files reviewed indicate that residents received services that are responsive to their needs, values and beliefs.</p> <p>Residents, families, and one general practitioner (GP) interviewed did not express any concerns regarding abuse or neglect.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>There were no residents who identified as Māori at the time of audit. The nurse manager reported that there are no barriers to Māori accessing the service. Staff interviewed demonstrated a good understanding of services that are commensurate with the needs of Māori.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>Residents' files reviewed demonstrated consultation with the resident and families on the resident's individual values and beliefs. Families reported they were consulted with the assessment and care plan development. Staff interviewed demonstrated good knowledge on respecting each resident's culture, values and beliefs.</p> |

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| <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>Staff employment documents had clear guidelines regarding professional boundaries. Families and residents interviewed reported they were very happy with the care provided. They expressed no concerns regarding breaches in professional boundaries and all reported a very high satisfaction with the caring, calming and professional manner of the 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 several examples of good practice implemented at Northanjer rest home. Evidence-based practice was observed, promoting and encouraging good practice. Engagement of external health professionals to support staff contributes to evidence based outcomes for residents.</p> <p>The nurse manager (NM) is supported in ongoing professional development. The NM and relief registered nurse (RN) are trained in interRAI assessments. The organisation has supported staff attending 'Hospice NZ' palliative care training, and pressure injury management training in 2016. The nurse manager has recently completed a Nursing Council of NZ audit. There is regular in-service education and staff access external education that is focused on aged care and best practice and fully supported by the organisation.</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>Staff demonstrated that they understand the principles of open disclosure. Residents, family members and the GP confirmed they are kept informed of the resident's status, including details of events which may have affected the resident. Evidence of open disclosure was documented within each resident's file. All interviewees reported that communication was excellent.</p> <p>At the time of this audit there were no residents who required interpreter services to ensure effective communication. Both the NM and staff demonstrated their understanding of the organisation's processes for obtaining these services should they be required.</p> |

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| <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>Northanjer is a rest home owned and managed by a husband and wife team who work as business and nurse managers respectively. They operate alongside another facility in Oamaru called Southanjer. All four owner/managers who form the governing board of the company meet monthly and an overview of the meeting minutes from these meetings was provided.</p> <p>The business plan is reviewed annually and outlines the purpose, values, scope, direction and goals of the organisation. The plan describes annual objectives, which include the plan to sell both facilities within this calendar year. Associated operational plans were reviewed and include goals and objectives. The nurse manager provides a monthly report to the governing board against these objectives on topics such as changes in residents, maintenance issues, finances and overviews of quality improvement and risk management topics.</p> <p>The mission statement, values and vision for the service are documented and are available to the general public on the website and in a promotional brochure. These focus on quality care, dignity, independence, compassion, professionalism and quality assurance. They are reviewed annually; however the nurse manager noted they do not really change.</p> <p>The nurse manager is a registered nurse with a current practising certificate. She has been managing the facility for 25 years. Documentation provided showed she has just been audited by the Nursing Council of NZ, which demonstrated she has maintained ongoing professional development and meets registration expectations. She is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and is supported by the business manager of Northanjer.</p> <p>The service is contracted by the Southern District Health Board to provide rest home services.</p> <p>The prospective providers are a couple who informed during interview that they have established a new company called 'Glenhayes', under which they will manage Northanjer. They will continue to trade this facility as Northanjer. Although the new company has yet to be fully</p> |
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| | | <p>defined, they noted that the basic structure of the shareholders forming the governance board, one of the couple providing business management and the other operations management has been decided upon. The operations manager is a physiotherapist with a current practising certificate and her partner has extensive management experience.</p> <p>Both the current and prospective managers independently reported that a transition plan is in place. Two weeks prior to the takeover date of 22 May the prospective operations manager will shadow the managers in both rest homes (Northanjer and Southanjer). For the following 30 working days the current managers will remain on site for as many hours as they are needed. The current managers have agreed to be only a phone call away and to provide assistance under contract until no longer required.</p> <p>The Ministry of Health has been advised of the intending change of ownership and the prospective managers are aware of the need to contact the portfolio manager of the district health board.</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 suitably qualified and experienced care manager from the other facility within the company (Southanjer) oversees the management of Northanjer in the event of a temporary absence of the care manager. The registered nurse from the other facility increases her hours to ensure there is registered nurse oversight during such an absence. Evidence of this was reported and provided.</p> <p>Documentation sighted during the provisional audit confirmed the reported plans for an additional registered nurse to be employed and share duties between the two facilities. This will provide additional cover in the absence of the manager.</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 quality and risk system that reflects the principles of continuous improvement and is understood by staff. Monthly staff meeting minutes showed staff are being updated on quality and risk management topics.</p> |

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| | | <p>Policies and procedures have been purchased from a consultant. These are updated biannually and when required. All necessary aspects of the continuum of service and contractual requirements are included and all documents that were reviewed were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff have access to paper copies of the policies and procedures and are updated on new policies or changes to policies through staff meetings.</p> <p>Six-monthly general committee meetings are the formal platform for the ongoing review of the quality and risk management system. These are held jointly with the four managers from the two facilities (Northanjer and Southanjer) and include registered nurse input. Meeting minutes reviewed confirmed that regular review and analysis of quality indicators, as detailed in the Quality Improvement Calendar, are being reported and discussed. Such activities include the use of restraints, complaint management, incidents/adverse event reporting, infections, internal audit results, education and training, unexpected care requirements, risk reviews, hazard management and preventive maintenance. Relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Resident and family surveys are completed annually. The last survey (September 2016) showed full satisfaction except for one person who made a comment about the environment. There was evidence that this was followed up.</p> <p>The nurse manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register was comprehensive and showed consistent review and updating of risks, risk plans and the addition of new risks that has been occurring.</p> <p>The prospective providers informed during interview that they do not intend to make any changes to the established quality and risk management system and have purchased the rights to the current associated documents including policies and procedures, the quality plan and the quality and risk management system.</p> |
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| <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>The nurse manager was able to quote different examples of essential notification reporting. These included the specifics around reporting infection outbreaks and when a change of manager needs to be notified to the Ministry of Health and the District Health Board. Such circumstances are also detailed in contracts and policies and procedures that were available and were reviewed.</p> <p>Staff document incidents, accidents and any adverse events on an accident/incident form. A sample of incidents forms reviewed show these are fully completed, open disclosure is occurring in a timely manner, incidents are investigated, action plans are developed and actions are followed-up. Documents sighted showed that adverse event data is collated, graphed and analysed each month. The information is reported through the six monthly committee meetings as well as at staff meetings. Meeting minutes reviewed show discussion in relation to trends, action plans and improvements made. Comparisons are being made between the two facilities. The information has revealed that most residents' falls are occurring in their rooms and strategies to reduce the incidence of these have been debated and trialled.</p> <p>The prospective provider informed they are aware of legislative compliance issues from their current workplaces and have read the documentation provided from the current providers and from the lawyers. They were open to being updated by the current providers once on-site.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes pre-employment interviews, referee checks, police vetting and validation of qualifications and experience. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>Current annual practising certificates for the nurse manager, the registered nurse, podiatrist, a physiotherapist and 12 local GPs who</p> |

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| | | <p>could potentially provide services to residents were on file and were all current. There is a sufficient number of trained and competent registered nurses who are maintaining their annual competency requirements to be able to undertake interRAI assessments as demonstrated by all residents having an up to date interRAI assessments on file.</p> <p>Staff induction/orientation processes and associated forms in the organisational human resources policies and procedures manual were reviewed. These describe all necessary components relevant to each role. The nurse manager informed there has not been any new staff for three years, which made it difficult to discuss the effectiveness of the orientation process with staff. Records in staff files reviewed showed that all had undertaken an orientation programme that had become more comprehensive over the years. An innovative system of managing performance reviews was in place. Records sighted showed that annual performance reviews have been completed for all staff.</p> <p>Continuing education is planned on a biannual/annual basis with the training schedule planned through to the end of 2018. Mandatory training requirements are defined and included in the training schedule, as are timeframes for the completion of quizzes on infection or restraints, for example. Timeframes for competencies such as handwashing and medicine administration to be assessed/reassessed are also detailed. Staff education records reviewed demonstrated the required training was being undertaken. Although some training sessions are shared with staff from Southanjer, especially those delivered by external trainers, most internal training is separate. Staff reported that they are given a wide range of training opportunities, including those provided by external training providers.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>Within the organisation's procedural documentation, there is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. This will be retained by the prospective provider. The nurse manager informed that staffing levels do not alter much, although the facility may adjust staffing levels if a person becomes temporarily unwell or requires non-complex short term palliative care. People are moved to other facilities following an updated</p> |

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| | | <p>needs assessment if they require care beyond that able to be provided within the rest home.</p> <p>The minimum number of staff is provided during the night shift and consists of one carer. There is adequate registered nurse cover as the nurse manager is a registered nurse and works a minimum of five full shifts a week. The registered nurse manager is also on call to assist after hours when needed. Carers reported during interview that adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a four-week roster cycle sample during this audit confirmed adequate staff cover has been provided. The organisation has sufficient staff to cover short notice roster gaps such as staff sickness, otherwise the manager will step in. Carers in this facility may be employed to undertake a range of duties in addition to caregiving. These include cleaning, laundry, activities and kitchen assistance. Some of these duties are specified on the roster.</p> <p>Staff are supported to update their first aid training every two years and the nurse manager ensures at least one staff member on duty has a current first aid certificate. This is identifiable on the roster.</p> <p>The prospective provider informed during interview that there are no immediate plans to change anything in relation to the way in which rosters are developed. Plans are in place for the prospective manager to live on-site at the other facility, Southanjer, which will mean there will no longer be any person on-site at Northanjer. The registered nurse from Southanjer who currently shares the on-call role in the absence of the current manager is expected to continue doing this on a more regular basis and will share this with a new registered nurse whose recruitment is underway. Three staff who live nearby and who have also previously assisted with on-call duties have been approached to do this on a rostered basis, as the current manager informed that most on-call duties are related to turning unwell residents during the night. The prospective manager informed she also intends to use local after hours services, or to call an ambulance should a person become acutely unwell. An advertisement has already been placed for an additional registered nurse who will share duties between Northanjer and Southanjer.</p> |
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| <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>All required details are used on labels as the unique identifier on all residents' information sighted. All necessary information was fully completed in the residents' files sampled for review.</p> <p>Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Training is provided to the administration and clinical staff annually on documentation requirements.</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>The NM logs enquiries and documents interview responses to gauge if the prospective resident is suitable for the facility. The residents are required to have an assessment for rest home level of care. The NM reported that she communicates regularly with referring agencies to ensure admissions are appropriate for the facility.</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>When admission is required to another provider (for example a higher level of care), the service completes a transfer form. The referral process documents any risks associated with each resident's transition, exit, discharge, or transfer. With the transfer form, the RN also provides a copy of any other relevant information, such as the medication chart. A file of the one resident reviewed with a recent transfer to another provider evidenced that the transfer was effectively managed.</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</p> | FA | <p>All aspects of medicine management are being undertaken according to medicine management policies and procedures, legislative requirements and the Ministry of Health guidelines for the management</p> |

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| <p>guidelines.</p> | | <p>of medicines in aged care facilities.</p> <p>Most medicines are supplied by the pharmacy in a blister pack administration system. The medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered. The pre-packed medicines and the signing sheets are compared against the medicine prescription. The GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists.</p> <p>Safe medicine administration was observed at the time of audit. All records were accurately completed.</p> <p>The medicines and medicine trolley were securely stored. The fridge where medicines are stored was monitored for temperature, with the sighted temperatures within medicine storage guidelines. Any controlled drugs were stored in a locked safe in a secure room. The service had no controlled drugs at the time of the audit.</p> <p>All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. The medicine charts recorded the regular, short course and pro re nata (PRN – as required) medicines for each resident. When medicines were discontinued, these were crossed out and signed and dated by the GP. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification was recorded for all staff who administer medicines. All of the medicine charts were reviewed by the GP in the past three months.</p> <p>Medication competencies were sighted for all staff that assist with the medicine management; this included the RN.</p> <p>The RN interviewed reported that there were no residents self-administering medication, however the facility has policies and procedures in place should this be required.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met</p> | <p>FA</p> | <p>A cook / carer manages the kitchen and was interviewed during the audit. The current menu was reviewed by a dietitian as being suitable for the older person living in long term care. If there are changes to the</p> |

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| <p>where this service is a component of service delivery.</p> | | <p>menu these are recorded and referred to the dietitian at the next review. A note book recorded any changes. All residents and families interviewed were very satisfied with the food and food services.</p> <p>Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met.</p> <p>There is food available at any time for those who wish to snack at night.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. Fridge and freezer recordings were undertaken daily and meet requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. Evidence was seen of all kitchen staff having completed safe food handling certificates.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | <p>FA</p> | <p>The NM reports that she has not declined entry to any potential residents who have an appropriate needs assessment. She confirmed that if entry to the service was to be declined the referrer, potential resident and where appropriate their family, would be informed of the reason for this and of other options or alternative services.</p> <p>The facility's admission agreement contained information on the termination of the agreement. This documents that if a resident's needs changed and if the service can no longer provide a safe level of care to meet the needs of the resident, they would be reassessed for the appropriate level of care.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | <p>FA</p> | <p>The service has fully implemented the interRAI assessment tool for all residents, and all assessments are current. The RN during interview demonstrated the links between interRAI, planning and reviews.</p> <p>Care plans sighted reflected the needs of the residents as identified in the interRAI. All residents' physical, psycho-social, cultural and spiritual needs are fully documented as part of the assessment process. Goals are individual and consistent with meeting the outcome needs of the</p> |

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| | | residents and the scores indicated in interRAI. A GP during interview confirmed that assessments are always timely and appropriate. |
| <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>Care plans sighted were all of a very high standard, reflected the interRAI outcome scores and triggers, were comprehensive and up to date. All triggers and outcome scores from the interRAI assessment were used to develop individual goals. Short term care plans are developed to manage any problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is consistent across care staff.</p> <p>Integrated files had one main folder that contained the medical information, nursing assessment, care plan, routine observations, activities, therapies, family correspondence and specialist consultations.</p> <p>Staff interviewed confirmed they were well informed and care plans were very clear and they were involved in the review process.</p> <p>The GP interviewed expressed a high level of satisfaction with the care provided.</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>Services are being delivered according to information in resident's individualised care plans.</p> <p>Short term care plans are being developed for short term problems, such as skin tears, wounds, decreased mobility and infections. Progress notes reviewed demonstrated that care and support was consistent with the identified problems, personal goals and interventions, as described in the care plans.</p> <p>Staff informed that they report any concerns about a resident, such as a change in their condition, both in the progress records and to the RN, and this was confirmed in documentation reviewed and interview with the RN.</p> |

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| | | Families and residents spoke very highly of the level of care and support provided and consistently stated that all of their needs are being met. The GP interviewed confirmed that his interventions ordered are always implemented. |
| <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>On admission, a personal profile is completed for each resident. A detailed and individualised activity plan is developed and updated during review. This includes triggers identified during the interRAI assessment. A range of activities are planned for each month and copies of the monthly activity schedules showed that options are varied.</p> <p>Two activities people implement the activities programme. During interview the activities person reported that options for group activities were discussed regularly with residents and family.</p> <p>Residents and families reported they are very happy with the activities available. They confirmed there is no compulsion to attend, or participate if they are in the lounge during activity time. Residents who wish are assisted to undertake activities on a one to one basis and a record of this was retained.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Evaluation of both short and long term care plans is occurring within recommended timeframes with detailed outcomes/goals included. Six monthly reviews of care plans are occurring. Both residents and families are consulted and are informed when changes are identified. This was confirmed during interviews and via the family communication forms.</p> <p>Information is being included in progress notes and changes are being made to interventions on care plans when indicated. Staff interviewed stated they are consulted prior to evaluations.</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</p> | FA | The GP arranges for any referral to specialist medical services when it is necessary. The residents' files reviewed had appropriate referrals to other health and diagnostic services. The RN confirmed that they utilise |

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| <p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | | <p>external services as much as possible. Referrals were sighted for consultations with general medicine, pathology, dietitian and radiology services. The GP interviewed reported that appropriate referrals to other health and disability services were well managed at the service.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>Documented processes for the management of waste and hazardous substances were in place. An amendment was made to this during the audit to improve the level of detail. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal. A contractor removes the general waste wheelie bins each week and recycling is taken to the local depot by the business manager every one to two weeks.</p> <p>Containers of chemicals were labelled and although the containers are primarily openable when attached to a dispenser unit, a key pad lock was installed on the door to the chemical storage area during the audit to ensure security. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. Such equipment included aprons, which staff were observed to change depending on their duty at the time, gloves, masks, goggles and a face shield. A sluice is available for staff use.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>A current building warrant of fitness with an expiry date of 24 July 2017 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme. Buildings and equipment are maintained to an adequate standard. The testing and tagging of electrical equipment, checking for safe hot water temperatures and</p> |

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| | | <p>calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas with garden ponds, an aviary and raised gardens some of the features. Efforts are made to ensure the environment is hazard free and that residents are safe. The use of ramps, rather than steps is one such example. Residents interviewed confirmed that they just ask one of the managers if any repairs or maintenance is required and said that any requests are appropriately actioned. They are happy with the environment and residents were observed to wander in and out, as well as walk the circuit around the lawns and gardens throughout the audit.</p> <p>A comprehensive safety audit is on the annual internal audit schedule and was last completed August 2016. This has a broad scope covering areas such as electrical items, call bells, lighting, heating, residents' equipment/aids, staff safety and a range of occupational health and safety requirements.</p> <p>The prospective providers advised during interview that they have no immediate plans to make any environmental changes to Northanjer and any changes would not be occurring within the next twelve months.</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> | <p>FA</p> | <p>There are adequate numbers of accessible bathrooms and toilets throughout the facility. Northanjer rest home has two spacious bathrooms in which there is a wet area shower, a toilet and a hand basin. There are three other separate toilets and hand basins in addition to staff and visitor toilets. Eight residents in one wing have an ensuite of a toilet and a basin. Bathrooms and toilets are lockable with access from the outside if needed.</p> <p>Handrails are installed and equipment, such as raised toilet seats, shower chairs and toilet frames, was available.</p> |

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| <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> | <p>FA</p> | <p>Adequate personal space is provided to allow residents and staff to move around within the bedrooms safely. There is adequate room for mobility aids such as walking frames and wheelchairs if required. All bedrooms provide single accommodation and all residents have a room of their own. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>Residents reported they are happy with their room and felt they had enough space and privacy.</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> | <p>FA</p> | <p>Several homelike communal areas are available for residents to engage in activities, seek privacy outside of their room or just to sit and relax in. Two separate lounge areas, one of which has a television, come off the dining area and provide optional types of comfortable seating. Seating in one large and one smaller separate conservatory is also available. Residents stated they like having the different areas they can go to and were observed mobilising freely between them.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | <p>FA</p> | <p>There is an on-site laundry where carers undertake the laundering of residents' personal items and the facility towels and bed linen. Carers demonstrated a knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Albeit small, the laundry set-up enables them to fulfil the laundry tasks effectively and efficiently. Staff interviewed were familiar with the management of soiled linen and confirmed they have time to undertake these tasks between resident cares. A laundry procedure and instructions for use of the equipment were available, as were chemical information sheets. Laundry detergents are delivered via dispensing units and the laundry door that has a key pad is kept closed.</p> <p>Carers also undertake cleaning duties. A cleaning schedule was sighted and is used to guide staff when undertaking the cleaning duties. Specific shifts are allocated for cleaning residents' rooms. The facility was clean and tidy throughout the audit. During the audit a key pad lock was installed onto an internal garage door to ensure residents do not access the garage where the cleaning trolley is stored and where</p> |

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| | | <p>two steps go to the where cleaning products are stored. The cleaning products require a dispenser connection to extract the contents.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | FA | <p>Policies and guidelines for emergency planning, preparation and response were available and key instructions were displayed. Staff undertake emergency management training and a fire drill as part of their mandatory annual training requirements. Monthly inspections of fire equipment, including the alarms and sprinkler systems is undertaken by a contractor and records confirming this is occurring were sighted.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on 2 November 2001. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 9 December 2016. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate and suitable equipment and supplies for use in the event of a civil defence emergency, including food, water (in a tank), blankets and a gas BBQ were sighted and meet the requirements for the fifteen residents. Records sighted show that the emergency supplies and equipment are checked six monthly when daylight saving occurs. Emergency lighting is tested alongside fire equipment checking.</p> <p>Call bells alert staff to residents requiring assistance. The whereabouts of a call is displayed on staff pagers and in the office, but can only be cancelled at the source.</p> <p>Appropriate security arrangements are in place. Doors are locked automatically at a predetermined time and all windows can only open a short distance.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> | FA | <p>All residents' rooms and communal areas have opening external windows on security latches. Infra-red thermostatically controlled</p> |

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| <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | | <p>heating panels with room by room controls are installed throughout the facility. Fan heaters are in shower rooms. Areas were warm and well ventilated throughout the audit and residents confirmed the facilities are maintained at a comfortable temperature. A conservatory is available for residents' use.</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 nurse manager (NM) and was interviewed. The job description for the infection control coordinator role is defined. There are clear lines of accountability for infection control matters at the service through the staff meetings. The NM attends these meetings. The NM provides a report to the staff meeting on IC matters.</p> <p>The annual review of the infection control programme has been conducted within the past 12 months.</p> <p>The service has 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. 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 service 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> | <p>FA</p> | <p>The NM attends ongoing education. The NM 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 staff and quality meetings and staff education occurs annually and randomly as part of the on-site audit process and as required at handover meetings.</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</p> | <p>FA</p> | <p>Northanjer rest home uses the organisation's detailed policies and procedures. Staff demonstrated good infection prevention and control practices reflective of policy. These have been designed to be fit for purpose and include best practice for the Northanjer's residential care environment.</p> |

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| <p>are practical, safe, and appropriate/suitable for the type of service provided.</p> | | |
| <p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | <p>FA</p> | <p>Infection control education is provided by the NM 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 families. The RN gave examples of encouraging residents with hand hygiene for all residents prior to their meal.</p> |
| <p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | <p>FA</p> | <p>The NM was interviewed in relation to surveillance activities. Monthly and annual analysis of infections are occurring and reported at six monthly to staff and quality meetings. Infection surveillance records showed a consistent low incidence of infections over the past year. The facility was proactively implementing measures to continually reduce infections. Training and recommendations were put in place when any infections occur to assist in minimising infection rates.</p> |
| <p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>A policy and procedure on restraint minimisation and safe practice was sighted and meets the requirements of the standard. Enablers and restraints are defined and the differences are clear. The restraint coordinator is the nurse manager. Reports on restraint use are tabled at the six monthly committee meetings, even though there have been no restraints used. Both restraint and managing challenging behaviours/de-escalation techniques are topics in the annual training schedules. Staff interviewed were clear about the difference between a restraint and an enabler and knew the need for an enabler to be voluntary and for the person to consent to its use. One enabler is being used and all relevant documentation, including the resident's consent, is in the person's clinical file.</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.

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| <p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | CI | <p>The NM has implemented a review of residents' interRAI assessments and utilises the information as an evaluation tool that informs each resident's care plan. For example, an ADL (activities of daily living) long form score showed an improvement on review. The score has decreased from 2 to 1 and the care plan goal outcomes and interventions reflect this improvement.</p> <p>There has been a detailed documented review with analysis of findings reported within the care plan to residents, families and staff. Residents and families involved in the process report an improvement in a consistent approach by all staff providing service delivery.</p> <p>A interRAI review process has occurred, improvements to the care plan to include outcome scores have been made as a result of review findings</p> | <p>The full integration of the interRAI triggers and outcomes into each resident's care plan and evaluation is at a level of continuous improvement. The NM has fully integrated findings from the interRAI assessment into residents' care plans at development and during the review process. Care plans sighted were all of a very high standard, reflected the interRAI outcome scores and triggers, were comprehensive and up to date. Feedback from residents, families and staff about service delivery has occurred and confirms the quality of care provided relating to the interRAI outcome scores and triggers. A review of the process showed improved satisfaction and resident outcomes.</p> |

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| | | <p>and resident satisfaction better outcomes have improved as a result. Evaluation of care plans and progress notes all provided evidence of improvement according to outcome scores.</p> <p>Positive feedback from residents and families about service delivery has occurred and confirms the quality of care provided. Staff reported that the detail in care plans provided them with all they need to know about caring for a person because the care plans are so clear, and they are involved in providing feedback at care plan review. Internal audits confirmed the effectiveness of the staff commitment to the care plans.</p> | |
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End of the report.