

# Ativas Limited - Cairnfield House

---

## Introduction

This report records the results of a Surveillance 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 Health and Disability Auditing New Zealand 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>	Ativas Limited
<b>Premises audited:</b>	Cairnfield House
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 18 March 2019 End date: 19 March 2019
<b>Proposed changes to current services (if any):</b>	Cairnfield House has reconfigured the certified services by the addition of one new room to be utilised as a dual-purpose room (hospital/rest home). This audit has verified the change of the configuration of services to a total of 88 beds consisting of; 20 hospital beds, 26 rest home beds and 42 dual service beds.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	81



# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
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

Cairnfield House is certified to provide rest home and hospital (geriatric and medical) level care for up to 88 residents. On the day of audit, there were 81 residents living at the facility.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures; a review of residents and staff files; observations; and interviews with residents, family, management, staff and a general practitioner.

The facility manager is supported by the director and clinical manager (registered nurse) who provides oversight of clinical care.

The service has addressed two previous certification shortfalls around corrective actions, and adverse events.

The service has addressed seven of ten previous partial provisional audit shortfalls around self-administration of medication for residents, aspects of the building requirements, fire evacuation training, and call bells. Improvements continue to be required around staff training, timeframes for interRAI assessments, and wound documentation.

Additional improvements identified at this audit are to ensure that the kitchen and staff are informed of dietary requirements; updating of care plans as changes occur and the activity programme.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
--	--	--

Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed they are provided with adequate information and that communication is open. Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints with these investigated in a timely manner. A register of complaints is kept.

## 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.
---	--	---

Cairnfield House is a residential care facility with leadership and management provided by the facility manager, who is a non-clinical manager, and the clinical manager.

There is an implemented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by the clinical manager. All aspects of the quality programme are discussed at relevant meetings. The health and safety programme is implemented.

Human resources are documented. An orientation programme is in place for new staff. Staffing is provided to support number and acuity of residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--	--	--

Care plans are developed by the registered nurses who have documented responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly.

There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner.

An activity programme is documented and displayed. This focuses on group activities for residents with two activities coordinators providing oversight of the programme.

All meals are prepared on site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents and relatives reported satisfaction with the food service.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
--	--	--

There is a current building warrant of fitness. Emergency and security systems 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.
---	--	--

Staff regularly receive training around restraint minimisation and the management of challenging behaviour. The service has maintained a restraint free environment. There is one bedrail in place with this identified as an enabler.

## 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.
---	--	--

A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

## 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	11	0	3	3	0	0
<b>Criteria</b>	0	40	0	3	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during entry to the service. Complaints forms are located at reception. A register of all complaints received is maintained. Three complaints were received in 2018 and none to date in 2019. A review of two complaints confirmed that the register was updated as complaints were received, that each complaint was processed in timeframes documented in policy and both showed that the complainants were happy with the outcome.</p> <p>Discussions with residents and families confirmed they were provided with information on the complaints process. All stated that they would raise any concerns or issues they had with the managers or with the registered nurses and all felt they would be resolved promptly. There was a high level of satisfaction expressed by family and residents interviewed. Thirteen residents were interviewed including eight identified as using rest home level of care (three were young people under the age of 65 years; two were using respite level of care) and five requiring hospital level of care (including one identified under a contract for long-term support for chronic health conditions who was also a young person under the age of 65 years). Residents stated that they could complain and felt they would be heard.</p> <p>There have not been any complaints made by external authorities since the last audit.</p>
Standard 1.1.9:	FA	There is an open disclosure policy. The policy also describes that open disclosure is part of everyday practice. The

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>care staff interviewed (including five healthcare assistants who work across all shifts, four registered nurses and the clinical manager) could describe the process for open disclosure and stated that they provided information and resource material to residents and family when required. Evidence of communication with family/whānau is recorded in the residents' progress notes.</p> <p>Families interviewed, (three including two with family in the hospital and one with a family member in the rest home identified as a young person with a disability) confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Ten accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the citizens advice bureau. Families and staff are utilised in the first instance.</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>The facility is owned by Ativas Limited and is managed by a facility manager. Cairnfield House has reconfigured the service to include the addition of one new room utilised as a dual-purpose room (hospital/rest home) as per agreement from the Ministry of Health dated 7 February 2019. This audit has verified the appropriateness of the room to function as a dual-purpose room with a change of the configuration of services to a total of 88 beds consisting of; 20 hospital beds, 26 rest home beds and 42 dual service beds.</p> <p>Occupancy on the day of the audit was as follows: 35 at rest home level (including four using respite care, one funded through the Long-term Support Chronic Health Conditions contract and one under an Accident Compensation Corporation contract); 46 hospital level (including two funded under the Long-term Support Chronic Health Conditions contract). Included in the numbers of residents, there were a total of seven residents under the age of 65 years including four using respite level of care, one ACC client and two under the Long-term Support Chronic Health Conditions contract.</p> <p>Cairnfield House has an overall business and continuous improvement plan in place for the current year with the previous plan reviewed prior to the new one being developed. A philosophy of care, which includes a mission statement is documented.</p> <p>The facility manager has been in the role for five years and they report weekly to the owner on a variety of operational issues. The owner is on site at least weekly and usually daily. The facility manager has completed more than eight hours of professional development in the past 12 months with management training included in this.</p> <p>The facility manager is supported by a clinical manager who is a senior registered nurse with a current practising certificate. They have completed at least eight hours of professional development relevant to the role.</p>
<p>Standard 1.2.3:</p>	<p>FA</p>	<p>A quality and risk management programme is established. Interviews with the managers and staff (including nine</p>

<p>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>care staff, maintenance staff, the cook and an activities coordinator) reflect their understanding of the quality and risk management systems.</p> <p>The service has policies, procedures and associated implementation systems. Policies are reviewed two yearly or as changes to legislation occurs. They are communicated to staff, as evidenced in staff meeting minutes. A document control system is in place.</p> <p>Regular resident and family meetings are conducted. These are held monthly prior to the staff meeting with minutes documented for each meeting. Annual resident and relative surveys are completed with a high level of satisfaction noted in the survey report from family and residents documented in May and October 2018. The resident and family meeting minutes showed that family and residents had been informed of the results. There was evidence of improvements identified in the survey made to the service.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Systems are implemented for the collection, analysis and evaluation of quality data. A range of data (eg, falls, pressure injuries, challenging behaviours, infections) is collected across the service. An annual internal audit schedule is documented, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data are benchmarked. Meeting minutes reviewed identified follow through actions on quality data/trends and results of internal audits. Corrective actions are implemented when service shortfalls are identified and signed off when completed. Data is collated and analysed with graphs displayed and discussion of results evident across a range of meetings held at regular intervals. A review of data confirmed that any issue or improvement is signed off as being resolved. The improvement required at the certification audit has been completed.</p> <p>Health and safety policies are implemented and monitored through the three-monthly health and safety and infection control committee meetings. A health and safety officer is appointed. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies with staff able to describe responses to and management of any emergency as per policy. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Falls prevention strategies are in place including physiotherapy input, sensor mats to alert when a resident is up and exercise programmes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	<p>FA</p>	<p>An accidents and incidents reporting policy is in place. There was evidence to support actions are undertaken to minimise the number of incidents. Ten accident and incident forms were reviewed. Neurological observations of a resident are documented as being completed following an unwitnessed fall. The improvement required at the previous audit has been completed.</p> <p>Adverse events are linked to the quality and risk management programme and accident and incident forms are</p>

<p>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>completed for the current pressure injuries. The improvement required at the previous audit has been completed. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events.</p> <p>The facility manager is aware of the requirement to notify relevant authorities in relation to essential notifications. A section 31 notification has been completed for pressure injuries identified on the day of audit (three grade three pressure injuries).</p> <p>The facility manager and clinical manager can identify a range of situations that required reporting to statutory authorities. The facility manager confirmed that there were no cases presented to the coroner for review for residents in the care centre or to any other external agency since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resource management policies in place. The recruitment and staff selection process require that relevant checks be completed to validate the individual's qualifications and experience and a review of staff files confirmed that this is completed. Copies of practising certificates are kept on site with these current for health professionals on site and for those visiting the service.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. There is an in-service education programme in place for which a record of attendance is kept. Healthcare assistants' complete qualifications in a nationally recognised aged care education programme. The facility manager, clinical manager and registered nurses attend external training, including sessions provided by the local DHB. An annual training plan is documented. The improvement required at the previous audit remains, however the service has put in strategies to improve attendance. The clinical manager and six RN's are interRAI trained and one is currently in training. Two more RNs are also booked in to complete.</p> <p>A plan has been put in place since the last audit to ensure that performance appraisals are completed annually. The facility and clinical managers have now caught up with completion of these and the previous improvement required to ensure these are completed annually has been addressed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	<p>FA</p>	<p>Service policy includes a staff rationale and skill mix. Enough staff are rostered on duty to manage the care requirements of the residents. At least one registered nurse is always on duty. Additional staff are provided for increased resident requirements.</p> <p>The clinical manager or a senior registered nurse are on-call after hours. The facility manager is also available at any time. Registered nurse cover is provided 24 hours a day, seven days a week with three registered nurses on both morning and afternoon shifts and a registered nurse on duty overnight.</p> <p>Healthcare assistants are allocated to each wing with consideration of numbers and acuity of residents. Rosters for</p>

<p>and/or experienced service providers.</p>		<p>the past three months reviewed confirmed that the following staff are allocated to morning and afternoon shifts: one healthcare assistant on Rimu and one on Puriri wings (rest home level of care with 26 residents); three healthcare assistants on Kowhai (21 beds – hospital beds); four on part of Kauri and Manuka wings (28 predominantly hospital beds); two on Kauri and Totara wings (13 hospital beds). Overnight, there are five healthcare assistants allocated to specific areas. The clinical manager also works during week days and a day is also given to a registered nurse to complete interRAI assessments.</p> <p>There is a total of 85 staff including 48 healthcare assistants, 14 registered nurses, two enrolled nurses; household staff (cook, cleaner, laundry staff), maintenance staff and two activity staff. Interviews with the residents and relatives confirmed staffing overall was satisfactory. A review of rosters confirmed that staff are replaced when on leave. Pharmacy, dietetics, physiotherapy and podiatry are contracted. The service has access to specialist practitioners from the DHB.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There is a signed agreement with the pharmacy. The RN checks all medications on delivery against the medication and any pharmacy errors recorded and fed back to the supplying pharmacy. The impress system is checked monthly. Expired medication is returned to the pharmacy.</p> <p>Three residents were self-administering medication on the day of audit. The residents concerned had self-medication competencies in place with documented supervision by the registered nurse. Young persons are supported to self-medicate if required. The improvement required at the previous audit has been addressed. The respite resident file reviewed had a paper-based file which was appropriately completed, signed and included any allergies and a photo.</p> <p>There are three medication trollies kept in the nurse's stations. All medications are securely and appropriately stored. The facility uses a robotic pack system. Registered nurses, enrolled nurses, and senior healthcare assistants that are responsible for the administering of medications have completed annual medication competencies. Registered nurses have completed annual syringe driver training and competencies.</p> <p>The medication folders include a list of specimen signatures. Photo identification and allergy status were documented on all charts. Fourteen medication charts (eight hospital and six rest home) sampled, had been reviewed by the GP at least three monthly. All resident medication administration signing-sheets corresponded with the medication chart. The medication round was observed during the audit and the medication process was noted to be correct and safe.</p> <p>The medication fridge has temperatures recorded weekly and these are within acceptable ranges. There are no standing orders.</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>All meals at Cairnfield House are prepared and cooked on-site by a cook/kitchen manager (qualified chef) who has worked in food preparation for many years. A second cook covers days-off. There are kitchen assistants who help with meal preparation. All staff have completed food safety training. There is a six-weekly seasonal menu, which had been reviewed by a dietitian in July 2016. Food preferences are met, and staff can access the kitchen at any time to prepare a snack if a resident is hungry. The cook receives a dietary profile of resident dietary requirements and any likes or dislikes; however, these are not updated after the admission of the resident. Special diets including modified foods and diabetic diets were provided at time of audit. Food is stored correctly and safely. Stock is rotated and dated.</p> <p>Staff were observed assisting residents with their meals and drinks in the dining rooms. Fridge, freezer, walk in chiller and end cooked temperatures are monitored daily. A kitchen cleaning schedule was documented, and cleaning was of an acceptable standard. Chemicals are stored safely within the kitchen.</p> <p>Resident meetings along with direct input from residents, provide resident feedback on the meals and food services. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>All resident files reviewed had care plans in place. At times the care plan is updated as changes occur because of a resident's change in condition or if needs alter. There was documented evidence of relative contact for any changes to resident health status.</p> <p>The wound register was updated with three pressure injuries documented, a check of a biopsy site, and one skin tag. Wound assessments, wound management plans and evaluation forms were partially completed for all wounds reviewed. A sample of wounds reviewed in detail included a link to STCPs and LTCPs. There is DHB wound care specialist/district nursing input where needed. Physiotherapy and dietitian input is provided for residents. The dietary assessment is not updated to reflect changes in diet for residents with significant wounds/pressure injuries, although there is reference to these in the long-term care plans. The kitchen staff were not familiar with or had dietary assessments to refer to around changes in dietary needs (link 1.3.13.2).</p> <p>The previous audit identified that there were shortfalls around the documentation of neurological observations. A review of a sample of recent falls related incident forms was undertaken. All the falls reviewed had a fully completed incident form with documentation of neurological observations as per policy.</p> <p>Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>Two activities coordinators are each working a 0.9 full time equivalent role across the service. They work across a seven-day week, and both are training to be diversional therapists. There are three volunteers who also provide activities, particularly to individual residents who are less mobile or engaged in the programme.</p> <p>The activities programme is documented, and a copy of the programme is in large print on the noticeboards with a copy provided to residents and families. The activities coordinators have ensured there are a variety of group activities, celebrations and outings to suit residents including all ages and all abilities. Church groups visit weekly and a priest provides communion on a Sunday. Seasonal events are celebrated. There are twice weekly van outings with visits to local places of interest, to other rest homes and there are sometimes boat trips on a Saturday. There are 'Apple Box' sessions where residents and families can display activities and pictures taken at recent celebrations up on the big screen for all residents to enjoy.</p> <p>For the younger resident admitted under a LTS-CHC, the activity coordinators have introduced google sessions where the resident can research areas of interest, with one young resident assisted to return to their place of home for lunch, another has been assisted to learn their native language. One resident helps with household chores and maintenance jobs.</p> <p>There are strong links with community which involves visiting kindergartens, visiting animals, weekly RSA visits, music entertainers and church services.</p> <p>Residents and families have the opportunity to feedback on the activity programme through meetings and surveys. Whiteboard sessions are provided where residents and families feedback on current activities and offer new ideas.</p> <p>A social history and activity plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed monthly. All the resident files sampled had a documented activity plan. A record is kept of individual resident's activities and monthly progress notes completed.</p> <p>On the day of audit, residents were observed being actively involved in the activities programme. Participation in all activities is voluntary.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Residents are reassessed (link 1.3.3.3) using the interRAI process. Long-term care plans are evaluated at six monthly intervals. While the evaluation is documented, the care plan is not necessarily updated.</p> <p>There was documented evidence that care plan evaluations were current in resident files sampled. Care plan reviews are signed as completed by the RN. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed, explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.</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>	FA	<p>The service displays a current certificate of public use. Medical equipment and electrical appliances have been tested, tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. Staff interviewed confirmed there is adequate equipment to carry out the cares, according to the resident needs, as identified in the care plans.</p> <p>Improvements required at the previous audit have been addressed. Balconies for residents in rooms on higher levels (as the service is on a hill) have external access doors, and balconies are now in place for these rooms. The grounds are now landscaped. There are external areas for all residents to use. Rooms have been furnished and handrails have now been installed.</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>Fire training and security situations are part of orientation of new staff - orientation checklist sighted. Staff training in emergency management includes fire safety and evacuation. There are staff across 24/7 with current first aid certificates. A trial evacuation/fire drill is documented as having occurred prior to occupation and the improvement identified at the previous audit has been addressed.</p> <p>The existing fire evacuation plan has been approved by the New Zealand Fire Service. Evacuation display panels have been installed for fire evacuations.</p> <p>Civil defence is covered in the risk management procedure. The service has emergency management supplies on site and these have been expanded to cope with the additional beds. Alternative energy systems are available in the event of the main supplies failing. There are large water tanks.</p> <p>The building has an electric call bell system installed throughout resident areas. All rooms, which will be used by residents, have a call bell system installed. Security systems are in place.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to staff at facility meetings. Outcomes and actions are discussed at facility meetings. If there is an emergent issue, it is acted upon in a timely manner, and where infection rates have been above an acceptable benchmark, corrective actions have been documented. Reports are easily accessible to the facility manager and clinical manager.</p> <p>There have been no outbreaks since the previous audit.</p>

control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers and comprehensive restraint procedures. The education and training programme includes regular in-service training on restraint minimisation. Interviews with the care staff confirmed their understanding of restraints and enablers. The service has a restraint-free philosophy.</p> <p>Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had no residents using restraints and one resident using a bed rail as an enabler.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	An education planner has been implemented and exceeds the provision of eight hours of training on an annual basis. Low attendance at planned and mandatory education sessions was identified at the previous audit and the managers have implemented a range of strategies to improve attendance. This includes payment for staff to come in on days off; games; nomination of a ‘staff of the month’; and questionnaires for staff to complete if they cannot come to sessions. Managers stated that despite new strategies implemented, there are still issues with attendance and questionnaires are not always returned when required. Attendance has improved; however, it remains with the risk rating remaining as low.	Attendance at in-service training is still low, (ie, below 50%) and the improvement required at the previous audit remains. The risk rating has not been increased as there is recognition for efforts made to improve attendance.	<p>Ensure that staff receive training as per the training plan.</p> <p>60 days</p>
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional</p>	PA Moderate	Each resident has a dietary assessment and profile completed on admission. The kitchen receives a copy of these. On the day of audit, the folder did not include any updated dietary profiles and the resident file did not have an updated version. Two dietary assessments in files reviewed	1. Dietary assessments for residents whose records had been reviewed by the auditor	1. Ensure that each resident has a dietary assessment

<p>requirements or special diets have these needs met.</p>		<p>had been updated and two were new residents and therefore assessments and profiles were current.</p> <p>There is a whiteboard that records dietary preferences, allergies and meal types in on a wall outside of the kitchen. This cannot be seen by others unless they specifically use this hallway to access the garage and it cannot always be sighted by kitchen staff.</p>	<p>did not have these reviewed. These were out of date and had not been updated to reflect current changes in diet. Dietary records in the kitchen were not reviewed at least six monthly or as changes occurred.</p> <p>2. The kitchen does not have an up to date record of resident preferences, meal types (eg, pureed meals) etc displayed on the whiteboard and the whiteboard is not able to be seen by kitchen staff when preparing or serving meals.</p>	<p>that is reviewed six monthly and updated as changes occur and ensure that the kitchen has a copy of these.</p> <p>2. Ensure that the dietary preferences, allergies and meal types can be seen by kitchen staff when preparing or serving food.</p> <p>60 days</p>
<p>Criterion 1.3.3.3 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>The service has struggled to retain registered nurses who have been interRAI trained in the past. There are now six registered nurses trained along with the clinical manager. A newly admitted resident showed that an interRAI assessment had been completed in a timely manner. One interRAI assessment had been completed in a timely manner, however this was noted to be in draft and not in the file as a signed off completed version. One interRAI assessment was not completed until three months after the resident had been admitted. One interRAI assessment had not been reviewed six monthly and one had been completed after the documentation of the review of the care plan. The improvement required at the previous audit has not been met. The risk rating and the timeframe to resolve the issues remains as per the previous audit.</p>	<p>InterRAI assessments for four of the six files reviewed were not completed in a timely manner as per ARCC contract.</p>	<p>Complete interRAI assessments in a timely manner as per ARCC contract.</p> <p>60 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Wound assessments, wound management plans and evaluation forms were at times poorly completed for wounds reviewed. The assessment, plan and evaluation of two pressure injuries for one resident were confusing as both injuries were documented on the same form. One resident has documentation of an assessment and plan completed by the district nurse. Staff are following the plan documented with review of each dressing documented. One resident has a well-documented assessment and plan for a wound. All have incident forms documented for each wound with these documented on the register. One surgical wound was documented using a short-term care plan with this well managed to resolution. One resident with a surgical wound did not have a wound assessment or plan documented.</p>	<p>(i)The assessment, plan and evaluation of two pressure injuries for one resident (tracer) were confusing as both injuries were documented on the same form. (ii) One resident with a surgical wound did not have a short-term care plan or wound management plan documented.</p>	<p>Ensure that each wound has a separate assessment, plan and review documented.</p> <p>60 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>The activities coordinator stated that residents who prefer to stay in their rooms have one-on-one time, which may involve a chat, hand massage or being read to. This is not documented on the activities programme.</p> <p>Two young people with disabilities (ACC funded) and two other young people under the age of 65 years (one using respite care and one with a long-term chronic condition) were interviewed. They stated that they were encouraged to be independent. Two of the four also stated that there were few activities planned for young people as part of the activities programme. The activities programme did not reflect activities planned for young people.</p>	<p>The activities programme does not include documentation of planning of activities for young people or for residents who do not wish or cannot engage in group activities.</p>	<p>Provide an activities programme for residents who are less able to engage in group activities and one for young people.</p> <p>180 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery</p>	<p>PA Low</p>	<p>Care plans were evaluated, but care plan interventions were not always updated as a result of a change identified through the interRAI reassessment or care plan evaluation. Short term care plans are in use and closed out when resolved.</p>	<p>Care plan interventions were not always updated as a result of a change identified through the interRAI reassessment or care plan evaluation</p>	<p>Ensure care plan interventions are updated as a result of a change identified through the</p>

plan.				care plan evaluation of interRAI reassessment.  90 days
-------	--	--	--	--

## Specific results for criterion where a continuous improvement has been recorded

---

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

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

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

No data to display
--------------------

End of the report.