

# Graceful Home No.2 Limited - Shelly Beach Dementia

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## 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 HealthShare 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:** Graceful Home No.2 Limited

**Premises audited:** Shelly Beach Dementia

**Services audited:** Dementia care

**Dates of audit:** Start date: 1 August 2019 End date: 1 August 2019

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 9

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

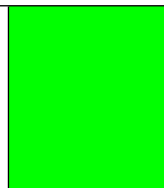
Graceful Home No.2 Limited - Shelly Beach Dementia provides dementia level care for up to 14 residents with an occupancy of nine residents on the day of the audit.

This unannounced surveillance audit was conducted against a subset of the relevant Health and Disability Standard and the contract with the District Health Board. The audit process included an interview with the owner/director, review of policies and procedures, review of resident and staff files, observations, a sample of quality related records and interviews with family, management, staff and a general practitioner.

There were three areas which were previously identified as requiring an improvement. Two of these have been sufficiently addressed. An additional 17 areas requiring improvement were identified during this audit. These include improvements to delegated authorities, policies and procedures, quality and risk related activities, adverse events, human resources, timeframes for service delivery, medicine management, food services and restraint.

## 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.

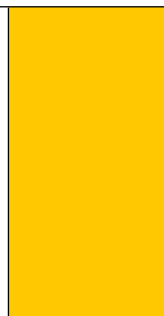


Standards applicable to this service fully attained.

It is reported that open communication between staff, residents and families is promoted. This was confirmed by family members interviewed. There is evidence that staff are aware of the residents' method for communicating. There is access to interpreting services if required. Systems are in place to ensure family are provided with appropriate information to assist them to help make informed choices on behalf of the resident. There are both formal and informal processes for family members to voice any concerns or make a complaint.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

There is a documented quality and risk management system. Management and staff meeting minutes sampled confirmed that data regarding service delivery is discussed and monitored. The owner/director is on site each week. There are processes for human resource management and rostering.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents are assessed by the Needs Assessment Service Co-ordination (NASC) prior to entry to the service to establish a level of care. The processes for assessment, planning, provision, evaluation, review and exit are provided by the registered nurse (RN). InterRAI assessments and individualised care plans were sighted.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Twenty-four-hour activity plans and diversional care plans are in place. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP).

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. A food control plan was in place. Nutritional snacks are available 24 hours.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There have been no changes to the facility since the last audit.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Shelly Beach Dementia has processes in place for determining safe and appropriate restraint and enabler use. The facility is a secure unit, and on the day of audit there were no residents requiring the use of restraints or enablers. Staff interviewed demonstrated a good understanding of restraint and enabler use. Restraint is part of orientation and training is provided annually or as necessary.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme is appropriate to the size and scope of the service.

## 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	8	0	0	2	7	0
<b>Criteria</b>	0	29	0	1	10	6	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>	<p>FA</p>	<p>There is a complaints management process. The duty leader/facility manager reported that there have been no external complaints to the Health and Disability Commissioner, the district health board or from other external agencies since the last audit. There is a complaint register, however there have been no recorded complaints. The last formal complaint on the register was in 2016.</p> <p>Family members interviewed confirmed that they have been advised of the complaints process on entry. An outline of the complaint's procedure is also included in the resident agreement. Family members interviewed had not raised any complaints to date and reported general satisfaction with the services provided.</p> <p>It was reported that many of the residents do not have family members who visit frequently, however special celebrations, for example Easter and Christmas, were conducted and all family members were notified and invited. This provides an opportunity for families to provide feedback to staff and management. The owner/director attends these celebration days.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	<p>FA</p>	<p>The duty leader/facility manager and registered nurse/clinical manager reported that the owner/director is approachable and open to any discussions regarding the care and support of residents, and any concerns reported by family. There was evidence in resident records that family have been contacted in the event of an incident, or a change in the residents' wellbeing. Advance care planning, establishing and documenting enduring</p>



<p>with consumers and provide an environment conducive to effective communication.</p>		<p>power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented.</p> <p>Access to interpreter services is available through the district health board if required. There were no residents who required interpreter services at the time of the audit. Staff were observed engaging with residents in a way that appeared effective.</p> <p>The residential agreement contains descriptions of the services to be provided for subsidised residents. This meets district health board requirements. Resident agreements are signed by the residents EPOA on entry and were sighted in resident files sampled.</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>PA High</p>	<p>The organisation is governed by the sole director who is supported by a business partner who provides financial support, a personal assistant, the deputy lead/facility manager and the registered nurse/clinical manager. The owner/director owns two other rest homes and has been working in the aged care sector since 2010. The organisation is a current member of the Care Association of NZ (CANZ) and the owner/director delegates attendance to cluster group meetings to the deputy lead/facility manager or the registered nurse/clinical manager.</p> <p>The owner/director has an office at one of the other rest homes. The owner/director is actively involved in operational management across the three facilities. The owner/director is on site weekly to catch up with the team. Weekly meeting minutes are documented and provide evidence that the owner/director is monitoring organisational performance. The owner/director was able to describe the mission and vision of the organisation, including the intent to embed tikanga into the organisation.</p> <p>The deputy lead/facility manager is onsite Monday to Friday business hours. The deputy lead/facility manager is supported by a registered nurse/clinical manager who was appointed in June 2019. An improvement is required regarding delegations, responsibilities and authorities for the senior team.</p> <p>The owner/director owns the business but does not own the facility. Shelley Beach can provide care for up to 14 residents requiring rest home - dementia level of care. There were nine residents at the time of the audit. Day care respite services are also provided. These are part funded by the district health board. There were no clients accessing respite services at the time of the audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	<p>PA High</p>	<p>Policies and procedures are purchased from an external consultant. In interview, the owner/director reported that there was a current business plan, however this was not sighted. There was some evidence that quality related data was discussed at both management and staff meetings. For example, staff meetings are attended by owner/director and include discussions regarding complaints and compliments, resident outcomes, adverse events, health and safety, internal audits and staff training. Infection control surveillance data is also collated and</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>analysed. There was also some evidence that correction actions were implemented if a gap in service delivery was identified, for example following an adverse event. Quality and risk management is included in the staff orientation. In interview, the owner/director was able to identify current risks to the organisation and actions to address them.</p> <p>Improvements to the quality and risk management system are required.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>Incident and accident prevention, management and reporting policies/procedures are in place. Incident records were tracked to confirm that the required processes are being followed. There was evidence that emergency actions were implemented and the required clinical observations documented. Investigation and monitoring of the adverse event process is the responsibility of the registered nurse/clinical manager.</p> <p>Improvement is required regarding essential notifications and the management of adverse event records.</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 High</p>	<p>Policies and procedures in relation to human resource management are documented. It was reported that there is a process for recruitment, orientation and training. The required recruitment activities are shared between the administrator, who has an office at one of the other sites, and the deputy lead/facility manager. Once records of criminal vetting and reference checks are completed, these are required to be forwarded to Shelly Beach.</p> <p>It was reported that all new staff receive an orientation to the facility and to their respective role. Health care assistants interviewed confirmed the orientation process. A record of orientation is retained on the staff file. Records of completed orientation include the essential components of service delivery, including emergency procedures and health and safety. Staff performance is monitored in an ongoing manner and annual performance appraisals were sighted in staff records sampled. A scheduled annual training plan is developed. Staff are required to have completed, or be enrolled in the required dementia training.</p> <p>There was insufficient evidence that the previously identified area of improvement has been addressed. Additional improvements are also required regarding the training programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>PA High</p>	<p>The service has a total of 11 staff including the registered nurse/clinical manager, the deputy lead/facility manager and health care assistants. A registered nurse from one of the other facilities has been providing 20</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>hours a week support to Shelly Beach, however this will decrease as the newly appointed registered nurse/clinical manager completes orientation.</p> <p>The documented rationale for determining service provider levels and skill mix is based on occupancy ratios. The duty lead/facility manager completes the roster two weeks in advance. The roster was sampled and confirmed there are sufficient numbers of staff to cover the 24-hour period. The registered nurse/clinical manager and owner/director are on call 24 hours a day, seven days per week.</p> <p>An improvement is required to ensure that suitably qualified staff are on duty at all times.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA High</p>	<p>The registered nurse/clinical manager was observed administering medications safely and correctly. The medication and associated documentation are in place. Medication reconciliation is conducted by the RN when a resident is transferred back to service. The RN checks medicines against the prescription and all medicines. There were no residents self-administering medications. The controlled drug register is current and correct. Weekly and six-monthly stock takes were conducted, and this was confirmed on previous entries. On the day of the audit, there were no residents prescribed controlled medication.</p> <p>Improvements are required regarding expired medications, medication competencies, three-monthly medication reviews and the security of the drug trolley.</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>The food service is provided on site and managed by two cooks. Kitchen staff have safe food handling qualifications and completed relevant food handling training. There is a current food control plan.</p> <p>The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Any special equipment, to meet resident's nutritional needs, is available.</p> <p>Family/whanau expressed satisfaction with the meals provided. Residents were given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Snacks are available on a 24-hour period.</p> <p>An improvement is required regarding the menu, diet profile reviews, temperatures, food monitoring and addressing resident's weight issues.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	<p>FA</p>	<p>The documented interventions in care plans were based on overdue interRAI assessments (refer 1.3.3.3). The GP interviewed, reported that medical input is sought in a timely manner, that medical orders are followed, and care is person centred. Health care assistants confirmed that care was provided as outlined in the</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>documentation. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs. Referral documents to other services and organisations involved in residents' support were sighted in the files reviewed. Interviewed families reported satisfaction with the services provided.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by the diversional therapist (DT). Social history and assessments are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. The activities programme developed is individualised and includes one on one and group activities. Activities reflect ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered.</p> <p>The diversional therapist develops an activity planner and daily/weekly activities are posted on the notice board. Residents' files have a documented activity plan that reflects the residents' activities identified in the social history and assessments. Twenty-four-hour activity care plans are developed for each resident. Activity progress notes are completed daily. Over the course of the audit residents were observed being actively involved in a variety of activities.</p> <p>The residents' activity needs were being evaluated but were not aligned to interRAI assessments and long-term care plans (refer 1.3.3.3). Family/whanau interviewed expressed satisfaction with the planned activities programme in place.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN to further investigate. Long-term and activity plan evaluations were being completed but not in conjunction with the six-monthly interRAI reassessment (refer 1.3.3.3). Where progress is different from expected, there was no evidence to indicate that the service responds by initiating changes to the plan of care (refer 1.3.3.3). Family/whanau interviewed confirmed involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	<p>FA</p>	<p>There have been no changes to the facility since the last audit. The fire service has approved the evacuation scheme and records of biannual fire evacuations indicated that fire drills are held every six months. Fire systems and emergency evacuation equipment is checked as required. Fire exits are labelled. There is a current building warrant of fitness. Electrical testing and tagging is conducted.</p> <p>Disaster plans are documented for a range of emergencies and outbreak management and pandemic planning is documented in line with the district health board guidelines. Adequate civil defence supplies are available with</p>

<p>emergency and security situations.</p>		<p>these stored in a locked area.</p> <p>The previously identified area of improvement regarding call bells has been investigated. The same call bell system remains in place, with call bells located outside residents' rooms. This has been deemed appropriate for this setting and family have been advised regarding methods to access staff in an emergency situation. The registered nurse/clinical manager reported that residents do not routinely use calls bells and that residents' where-a-bouts is monitored at all times by the health care assistants.</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 programme is appropriate for the size and complexity of the service. Shelly Beach Dementia provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The registered nurse/clinical manager is the infection control coordinator. Responsibility for the role of the infection control coordinator is defined in the documented quality and risk management system.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented since the last audit.</p> <p>The previously identified area of improvement regarding the annual review of the infection control has been addressed. There was some evidence that the programme was reviewed by the previous registered nurse/clinical manager prior to leaving.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed for all diagnosed infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is</p>	<p>PA High</p>	<p>Shelly Beach Dementia has a commitment to provide quality services for residents in a safe environment and work to minimise the use of restraint. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. Restraint is part of orientation. Approved restraint and enablers include bed sides and lap belts respectively, however these were not in use during the time of the audit.</p> <p>An improvement is required in ensuring that residents' access to walk outside within the secure outdoor area is</p>

actively minimised.		not restricted.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	PA High	<p>The deputy lead/facility manager has been working at Shelley Beach for 10 years as a health care assistant and has the required dementia training. The newly appointed registered nurse/clinical manager is new to the aged care industry and is on site for 20 hours per week. It was reported that the registered nurse/clinical manager has access to another registered nurse who works at one of the other facilities. Position descriptions for both the deputy lead/facility manager and the registered nurse were sighted. The deputy lead/facility manager’s position description did not include the authorities or responsibilities required of a facility manager and the registered nurse/clinical manager position description did not include clinical management or the activities required regarding implementation of the quality management system.</p>	<p>The authorities and responsibilities for the duty lead/facility manager and the registered nurse/clinical manager are not defined in position descriptions.</p>	<p>Define responsibilities and authorities for the deputy lead/facility manager and the registered nurse/clinical manager.</p> <p>60 days</p>

<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	<p>PA Moderate</p>	<p>Policies and procedures are provided in hard copy and are stored in the office. The document control/review policy requires all policies and procedures to be reviewed annually and there is evidence that changes in legislation have been included in the policy reviews, for example health and safety, however there was no evidence that policies and procedures are being routinely reviewed as required. A number of policies and procedures sighted were dated 2013 to 2015.</p>	<p>Unable to determine if policies and procedures have been routinely updated and reviewed as required.</p>	<p>Maintain evidence of reviews and amendments of policies and procedures.</p> <p>90 days</p>
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	<p>PA Moderate</p>	<p>The documented quality management system requires quality and business goals to be documented and monitored. The system requires defined quality goals and actions to achieve them. A current business plan or quality plan was not sighted during the audit and there was no evidence that actions to address quality goals were implemented or documented. The system also requires satisfaction survey to be completed. This has not occurred.</p>	<p>Unable to verify the implementation of a number of quality activities.</p>	<p>Maintain evidence that the required quality related activities are being implemented as required.</p> <p>60 days</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>PA Moderate</p>	<p>The documented quality management system requires a number of internal audits/checklists to be routinely completed against a schedule. Internal audits/checklists for the year 2018 and 2019 (to date) were not sighted.</p>	<p>There is no evidence that internal audits/checklists have been completed as required.</p>	<p>Conduct internal audits/checklists as required.</p> <p>90 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their</p>	<p>PA Moderate</p>	<p>Risks to the organisation could not be confirmed during the audit. In interview the owner/director discussed current business risks and clinical risks are identified on resident care plans, however the process for identifying and monitoring risk could not be confirmed during the audit.</p>	<p>Risks to the organisation are not defined. There is no evidence that</p>	<p>Define and monitor risks to the organisation.</p>



family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.		The business/risk plan was not sighted.	risks are monitored.	60 days
Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.	PA Low	There was some evidence that family and/or the general practitioner were contacted following an adverse event. Notifications are recorded on the adverse event form. The policies and procedures also identify the required notifications, however the Ministry of Health (MOH) were not notified regarding the employment of a new clinical manager.	Unable to verify that essential notifications have been made as required.	Provide evidence that essential notifications are made as required.  60 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Adverse events are documented using an incident/accident form. These are then forwarded to the registered nurse/clinical manager for investigation and closure. Adverse event records were sampled. There was insufficient documentation in resident records to describe the event. There was also evidence that not all adverse events had been documented. For example, it was reported that one resident had recently had an unwitnessed fall and no record of this event could be found (refer criterion 1.3.3)	There is insufficient evidence that all records of adverse events have been maintained.	Maintain records of adverse events.  60 days
Criterion 1.2.7.2 Professional qualifications are validated,	PA Moderate	The previous audit identified issues regarding missing staff records for criminal vetting and reference checks. It was	Unable to verify the recruitment	Provide evidence of staff

including evidence of registration and scope of practice for service providers.		reported that these processes had been completed, however related records were not sighted during the audit. Staff files for two staff who had recently been employed were also not sighted.	process.	recruitment records.  60 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	All staff are required to have the required dementia training, or be enrolled. Evidence of dementia training could not be confirmed during the audit. The registered nurse/clinical manager has not received any training in dementia care and is yet to complete interRAI training.	There is insufficient evidence that all staff have the required training.	Provide evidence that staff have the required dementia training.  90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	It was reported that a number of training opportunities are provided in order to meet contract requirements. Health care assistants interviewed confirmed that they had access to sufficient training, however staff training records were not sighted during the audit.	Training records for the year 2018 and 2019 were not sighted.	Provide records of staff training.  90 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA High	All staff are required to have a first aid certificate. Current first aid certificates for staff could not be confirmed. There is one staff member on duty during a night shift. This staff member's first aid certificate has expired.	There is insufficient evidence that all staff have a first aid certificate. This includes the health care assistant who is the only staff member rostered on a night shift.	All staff are required to have a first aid certificate.  90 days

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA High</p>	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for using an electronic system was observed on the day of audit. Indications for use are noted on 'as required' medications, allergies are clearly indicated, and resident photos were current. Administration records are maintained, and medication incident forms are completed in the event of any drug errors. Not all three-monthly GP medicine reviews were completed and there was expired 'as required' medications in stock. The drug trolley was not secure. The trolley is kept in the dining room (unsecured) and the lock was broken.</p>	<p>Not all medication requirements have been maintained.</p>	<p>Meet all medication guidelines, legislation and regulations.</p> <p>30 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA High</p>	<p>The staff interviewed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management, however there was insufficient evidence that all staff have completed the required medication competencies. This is particularly relevant to senior staff members.</p>	<p>Medication competencies for all staff who administer medications were not sighted.</p>	<p>Complete medication competencies for all staff who administer medication.</p> <p>30 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Moderate</p>	<p>The menu follows summer and winter patterns and a nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The residents' weights are monitored monthly and documented. There was no documentation in the long-term care plan addressing weight issues for one resident (refer standard 1.3.3). The menu has not been reviewed by a registered dietitian and resident diet profiles were not reviewed in a timely manner.</p>	<p>There is no evidence that the menu and dietary profiles have been reviewed in a timely manner as required. There were no interventions addressing weight issues of</p>	<p>Provide evidence of the menu review and current dietary profiles. Develop interventions that address resident's weight issues.</p>

			one resident in the long-term care plan sampled.	90 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Moderate	Some aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food control plan. Labels and dates were on all decanted food. There were no records sighted of temperature monitoring of food, fridge, freezers and regular cleaning of the kitchen.	Temperature records of the fridge, freezer, food and records of regular cleaning of the kitchen have not been maintained.	<p>Maintain evidence of temperature and kitchen cleaning records.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA High	Initial admission assessments are completed in a timely manner and resident care plans are completed within three weeks of admission along with interRAI assessments. The RN develop residents' care plans. Formal care/activity plan evaluations were being completed but not in conjunction with the six-monthly interRAI reassessment. Where progress is different from expected, there was no evidence to indicate that the service responds by initiating changes to the plan of care. Interventions in the long-term care plans were based on overdue interRAI assessments, with some last being reviewed January 2018. There was no evidence that short-term care plans identifying and addressing resident acute needs had been developed.	Timeframes for assessments, care plans and activity plans are not being met.	<p>Meet timeframes for assessment, care plans and activity plans.</p> <p>90 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the</p>	PA High	The service has no residents using an approved restraint or enabler. A restraint register is in place. Environmental restraint was observed during the audit. This consisted of locking external doors, restricting residents' access to the secure grounds. The use of environment restraint was not	Environmental restraint is in use. This is not identified within the restraint	Discontinue the use of environmental restraint.

intention of promoting or maintaining consumer independence and safety.		included in the restraint policy.	programme or the individual client records.	90 days
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.