

# Stanthom Properties Limited - San Michele Home and Hospital

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Stanthom Properties Limited
<b>Premises audited:</b>	San Michele Home and Hospital
<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: 29 August 2019 End date: 30 August 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	24

# 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

San Michele Home and Hospital (San Michele) provides rest home and hospital level care for up to 29 residents. The service is operated by Stanthom Properties and managed by a nurse manager.

This re-certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board.

The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the owner, a manager, staff and a general practitioner. Residents and families spoke positively about the care provided.

Eight areas for improvement were identified during the audit. These relate to complaints management, essential notification reporting, the effectiveness of the internal audit system and lack of a quality plan, performance appraisals for senior management (the nurse manager and senior RN), residents' assessments and care planning, review of medicines, and maintenance and testing of biomedical equipment.

## Consumer rights

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

Some standards applicable to this service partially attained and of low risk.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained. Residents and families had been informed, understood their right to complain and understood the processes for raising their concerns or complaints.

## 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.
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The business and risk management plans include the scope, direction, goals, values and mission statement of the organisation. The nurse manager has been in the role for three years and employed as a registered nurse (RN) at San Michele since 2002.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. A sector standardised policy set was being implemented during the audit.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery. Regular individual performance review has occurred for all staff with the exception noted in the general overview. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## 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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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner and/or nurse practitioner, assess residents' needs on admission. Care plans are completed and families and residents interviewed confirmed that the residents' needs are provided. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## 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>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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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness.

Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

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

## Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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The organisation has implemented policies and procedures that support the minimisation of restraint. Staff have successfully eliminated the need for restraint by providing alternative interventions for the people who used to have bed rails in place. Two

residents interviewed confirmed that the bedrails and lap belts they used were voluntary and necessary for their safe mobility. Staff interviewed demonstrated a sound knowledge and understanding about the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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	37	0	2	6	0	0
<b>Criteria</b>	0	85	0	2	6	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The facility has recently integrated new policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code (refer to 1.2.3)). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the facility's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the</p>

		resident's record. Staff were observed to gain consent for day to day care.
<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>During the admission process, residents are provided with an introduction booklet which includes information about the Code of rights and Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The registered nurse provided examples of the involvement of an independent Advocate based in the community that frequently visits the residents at the facility, is available to families and has also provided training for staff.</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>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Residents interviewed confirmed that they are often supported by families and friends and attend regular events and social gatherings.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Along with the residents' bedrooms, there are two main communal lounges, a smaller alcove and outside sitting areas where residents can spend time with families and visitors.</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>	PA Low	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to raise concerns and what to expect when they do so. There are complaint forms on display in common areas.</p> <p>The complaints register records three complaints received since the</p>

		<p>previous audit in August 2018. Two of these had not been acknowledged in writing and there was no evidence of investigation or resolution. An improvement is required in 1.1.13.1. Senior staff are responsible for complaints management and follow up.</p> <p>All other staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints submitted to the Office of the Health and Disability Commissioner since the previous audit. A hard copy complaints register is being maintained.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, through discussions with staff and the independent advocate support liaison based in the community. The Code is displayed in the main areas of the facility together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room and/or share a room with persons with their consent.</p> <p>Residents are encouraged to maintain their independence by attending community activities, participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Staff, resident and family interviews confirmed that resident's individual cultural, religious and social needs, values and beliefs had been identified and supported in the resident's day to day living; however, this information was not always evidenced and documented and incorporated into their care plan (see criterion 1.3.5.2).</p>

		Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
<p><b>Standard 1.1.4: Recognition Of Māori Values And Beliefs</b></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>	FA	Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. The registered nurse interviewed reported that there is one resident who affiliates with their Maori culture. The registered nurse, care staff and diversional therapist interviewed knew the resident well and was able to discuss and provide examples of how they incorporate and support the resident's values and beliefs. There is no specific current Māori health plan. This information was acknowledged in the initial nursing and activities assessment on admission but was not highlighted and integrated throughout the residents' long-term care plans (see criterion 1.3.5.2). The resident and family members were not available to be interviewed at the time of audit.
<p><b>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</b></p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	Residents and families interviewed verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Staff interviewed knew the residents well and were able to identify the resident's specific needs, family support and preferences. The resident's individual culture was acknowledged in the initial nursing and activities assessment on admission but was not always highlighted and integrated throughout the residents' long-term care plans and nutritional profile (see criterion 1.3.5.2).
<p><b>Standard 1.1.7: Discrimination</b></p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the

		required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through the evidence of newly integrated policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes and ophthalmology team, wound care specialist, psychogeriatrician and mental health services for older persons, and podiatrist, and education of staff. The facility is supported by two medical practices and a nurse practitioner. The general practitioner (GP) interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. The care provided by staff was resident centred and of a high quality.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included observed day to day discussions and interactions between staff, residents and families and good hand hygiene infection control practices.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English, staff able to provide interpretation as and when needed and the use of</p>

		family members.
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. The owner is provided information by email and telephone on occupancy numbers every month and any emerging risks, such as staff changes, as they occur. The owner is on site two days a month to complete building inspections and meet with management and staff.</p> <p>The service is managed by a nurse manager who holds relevant qualifications and has been employed by the service for 18 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement.</p> <p>The service has an Aged Residential Care contract (ARC) with Waikato DHB for delivery of rest home and hospital services (medical and geriatric) and for short term respite care. San Michele has a maximum occupancy of 29 residents. There were 24 residents on site on the first day of audit. This comprised 18 residents receiving hospital level care, including one person under the age of 65 years funded as Long term Support-Chronic Health Condition and one resident funded by the Accident Compensation Corporation (ACC) for rest and recuperation following surgery. Six residents were receiving rest home level care.</p>
<p><b>Standard 1.2.2: Service Management</b></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>	FA	<p>In the absence of the nurse manager, the senior RN deputises with input from the owner and the office manager. The NM and senior RN confirmed their responsibility and authority for these roles.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	PA Moderate	<p>The organisation has started using a sector specific quality and risk system which reflects the principles of continuous quality improvement. This includes management and reporting of incidents and accidents, complaints, internal audit activities and monitoring of</p>

<p>continuous quality improvement principles.</p>		<p>outcomes, regular resident and relative satisfaction surveys, and clinical incidents including infections. This had not been fully embedded on the days of audit. Except for the success achieved in restraint (refer 2.2.1) the quality and risk management activities carried out since the previous audit are not leading to improvements or effectively preventing risk. The quality plan expired in 2018; an improvement is required in criterion 1.2.3.7.</p> <p>Documents reviewed confirmed monthly review and analysis of incidents, accidents and infections. Staff meeting minutes confirmed that this information is reported and discussed at each meeting. Staff reported their involvement in quality and risk management activities through the annual internal audit process. The audit tools do not check for legislative, regulatory or contractual compliance. There is an improvement required related to this in criterion 1.2.3.7.</p> <p>A comprehensive resident and family satisfaction survey is completed annually. The most recent survey in November 2018 had a 90% return rate and revealed a high satisfaction. Other surveys such as staff wellness and food satisfaction are conducted throughout the year.</p> <p>A new policy set based on best practice has just been acquired and was being implemented. The policies are moderated by an external quality consultant which provides a systematic and regular review process. The policies are controlled and contained references to legislation and regulations.</p> <p>The office manager who is the nominated health and safety officer described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager was familiar with the Health and Safety at Work Act (2015) and has attended training for the role.</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>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at monthly staff meetings. Incidents of</p>

		<p>high risk are reported and discussed with the owner.</p> <p>A stage 4 pressure injury was not notified to the DHB or MoH as required under section 31. There have been no investigations by the Office of the Health and Disability Commissioner.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed that APCs for the RNs, GPs and physiotherapist were current and copies are on file. The service provider has enrolled with the NZ Police to facilitate police vetting of applicants but stated this is not mandatory and will only do so where this is indicated. The records show that referee checks had been undertaken. Job descriptions for the infection control coordinator and restraint coordinator are allocated to appropriate staff.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a sixty-day period. The nurse manager is attending ongoing training relevant for managers of aged care facilities. All but one of the 17 caregivers are long term employed with an Aged Care Education (ACE) certification, but not all intend to progress the NZQA unit standards. One person has The National Certificate in Health and Wellbeing (level 4) and one person has achieved level 3.</p> <p>Continuing education is planned on an annual basis and includes mandatory training requirements. Each of the five RNs have comprehensive first aid certificates and have been assessed as competent to administer medicines. Attendance records confirmed that all care staff are participating in the monthly in-service training days.</p> <p>There is at least eight hours of education related to the care of older people being provided each year which meets the requirement of the ARC contract. The only registered nurse trained and maintaining annual competency requirements to undertake interRAI assessments</p>

		<p>is the nurse manager. Confirmation of the cook having achieved unit standards 163 and 168 Safe Food handling was sighted.</p> <p>The nurse manager and senior RN have not had a performance appraisal since 2013. An improvement is required in 1.2.7.5. The ARC contract requires that all staff engage in annual performance appraisals. All other staff files sampled contained evidence of a performance appraisal having occurred in the past 12 months.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7).</p> <p>The service has been short one RN since April 2019, but this person is returning to work shortly. The total number of RNs employed is five (one on maternity leave).</p> <p>There is at least one RN on site 24/7. The nurse manager is working three to four shifts a week on the floor to cover and to meet the requirements. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Allocation of care staff is adequate for example, four caregivers for 18 hospital residents each morning, and three in the afternoon.</p> <p>Staff interviewed said there were enough staff available to meet residents' needs and this was confirmed by observations on the days of audit. Residents and family spoke highly of the carers, their cheerful disposition and teamwork. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. There is a separate</p>

		<p>folder that holds the residents short, long term and wound care plans and recent progress notes. This information is integrated into the resident's main folder as required. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with a tour of the facility and information about the service and the admission process. The facility seeks updated information from disability support groups (DSL/NASC) and the GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. Families interviewed reported being kept well informed</p>

		during the transfer of their relative to an acute hospital setting.
<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>	PA Low	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The clinical pharmacist's input is provided fortnightly. The controlled drug register showed a history of weekly stock checks not been completed. This issue was highlighted on the 23 July 2019 by senior staff and regular stock checks are now occurring every week.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart; however, at the time of audit two GP reviews were overdue. Standing orders are not used. Vaccines are not stored on site.</p> <p>There were three residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any</p>

		medication errors.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a head cook, is supported by another three cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries and expires on the 2 July 2020. The facility is booked to have a food verification audit in September 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The head cook has undertaken a safe food handling qualification.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile is developed and sent through to the kitchen. The kitchen staff are then verbally made aware of any changes to personal food preferences, any special diets and modified texture requirements for residents' nutritional needs and these changes are accommodated in the daily meal plan. This information is not always updated as changes occur in nutritional profiles or in long term care plans (see criterion 1.3.5.2).</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and</p>

<p>organisation, where appropriate.</p>		<p>they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. The registered nurse interviewed stated that there is no history of residents been declined admission to the facility other than when no bed was available. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>Information is documented using validated nursing assessment tools, such as apain scale, falls risk, skin integrity, nutritional screening and oral care, as a means to identify any deficits and to inform care planning. All residents have current interRAI assessments completed by one trained interRAI assessor on site. The sample of interRAI assessments reviewed had been completed after the development of the resident's long-term care plans and neither the interRAI or long-term care plans always reflected up to date assessments and/or interventions. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written. Residents and families reported participation in the development and ongoing evaluation of care plans. Staff interviewed knew the residents well. Any required change in care is verbally passed on to relevant staff and implemented but this was not always documented. The needs of the residents and outcomes of allied support intervention were not always reflected in the interRAI assessments or long-term care plans reviewed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Observations and interviews verified the care provided to residents was consistent with their needs and goals, but the documentation of the care was not always evident in the care planning (see criterion 1.3.5.2). The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The</p>

		<p>general practitioner (GP) interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. The care provided by staff was resident centred and of a high quality. Care staff confirmed that care was provided as outlined in the documentation and based on needs. A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy and supports the residents from 9.00 am to 1.00 pm Monday to Friday.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six monthly interRAI assessment care plan review. Cultural, spiritual values and beliefs are supported to meet the needs of the individual residents for example external resources, music, cultural/language programmes on TV, food and support of staff and families.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions and satisfaction of activities attended. Residents interviewed confirmed they find the programme interactive and stimulating and look forward to the regular outings with residents of other local facilities, for example, the stroke club, workingmen's club, women's group and other community-based activities. The facility also invites community groups and entertainment on a weekly basis to support residents less mobile and interactive.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p>

<p>comprehensive and timely manner.</p>		<p>Formal care plan evaluations occur every six months; however, not always in conjunction with the six-monthly interRAI reassessments which have been completed prior to the update of the long- term care plans (see criterion 1.3.4.2). Prior to the interRAI been updated the staff collectively, along with allied support professionals, complete a template providing information to support the interRAI trained nurse in completing the resident's interRAI. Where progress is different from expected, the service responds, and care is provided as needed; however, this information is not updated to the plan of care (see criterion 1.3.5.2). Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the facility has the support of two medical centres and a NP, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP/NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to mental health services for older persons, podiatry, a physiotherapist, ophthalmology services, and a diabetes specialist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Cleaning, laundry and kitchen staff have completed training in safe chemical handling. An external company is contracted to supply and manage all chemicals and cleaning products and they provide ongoing support and training for staff. Material safety</p>

		<p>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 which staff were observed using.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>There was a building warrant of fitness which expires on 17 June 2020.</p> <p>Systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment occurred in July 2019 as confirmed by visual inspection and documentation reviewed. The environment was hazard free and resident's safety and independence was promoted.</p> <p>Checking and calibration of bio medical equipment has not been maintained, an improvement is required in criterion 1.4.2.1.</p> <p>External areas are regularly checked for safety and are appropriate to the resident group and setting. There is sufficient shade and seating on the veranda and in the grounds. Paths and walkways are slip free.</p> <p>Residents and staff confirmed they know the processes they should follow when repairs and maintenance is required. The office administrator has authority to action urgent repairs by suitable tradespeople.</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 bathrooms and toilets throughout the facility. All bedrooms have a wash hand basin. Residents and families reported that there are sufficient toilets and they are easy to access. Appropriately secured and approved handrails are provided, and other equipment is available to promote residents' independence.</p> <p>Hot water is delivered at a safe temperature and is tested regularly.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p>	<p>FA</p>	<p>Of the 12 allocated hospital bedrooms, seven are for single accommodation. The other five bedrooms are occupied by two or</p>

<p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>three residents. Each of the rest home bedrooms has one occupant. Adequate personal space is provided for residents and staff to move around within the bedrooms safely. Residents and families stated their or their relative's accommodation is adequate. Rooms are personalised with furnishings, photos and other personal adornments. There is room to store mobility aids as needed.</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>The home has combined lounge/dining areas in the hospital and the rest home. These spaces are also used for activities. The areas are easily accessed by residents. The rest home dining area is spacious with suitable furniture, and residents can choose to have their meals in their rooms. Hospital residents who require support are assisted with eating by staff, in an unhurried way.</p> <p>Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</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>All laundry is washed on site. Residents and family reported the laundry is managed well and residents' clothes are returned in a timely manner. The two cleaning staff also provide the bulk of laundry services. Either one of them is on site seven days a week for at least seven hours. There is at least one day a week where both cleaners are on site. These staff have attended education on safe handling of chemicals. Visual inspection confirmed that chemicals were in appropriately labelled containers and were stored securely.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and by the chemical supply company. There have been no concerns and the system for laundry and cleaning is functioning well.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct staff in their preparation for disasters and describes the procedures to be followed in the event of a fire or other</p>

		<p>emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in 1999. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 19 June 2019. The owner/operator is an ex fire officer and provides regular education and competency testing for staff. The onsite fire suppression systems are checked monthly by an appropriately qualified company.</p> <p>The orientation programme includes fire and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for a maximum 29 residents and the Ministry of Civil Defence and Emergency Management recommendations for the region. The emergency lighting system is regularly tested by the owner who carries out monthly inspections.</p> <p>The call bell system was functioning on the day of the audit and residents and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. There have been no security incidents.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and doors. Heating is provided by electricity in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit. Residents and families confirmed the facilities are maintained at a comfortable temperature.</p> <p>The organisational smoke free workplace policy is known and adhered to by staff.</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</p>	<p>FA</p>	<p>The facility implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. This programme is guided by a comprehensive and current</p>

<p>be appropriate to the size and scope of the service.</p>		<p>infection control manual, with input from external providers as required.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the nurse manager and tabled at registered nurse and full staff meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</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 IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for three years. She has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. A new infection control programme is currently been implemented and includes appropriate referencing (refer to 1.2.3).</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified</p>

		knowledge of infection control policies and practices.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hotter weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers.</p> <p>The facility has had a total of 21 infections since February 2019 through to and including July 2019. Residents' files reviewed highlighted short-term care planning but this information was not identified in the long-term care planning to reduce and minimise the risk of ongoing infections (see criterion 1.3.5.2). Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. There have been no infectious outbreaks. Benchmarking does not occur.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is a caregiver with a sound understanding of these standards, the restraint policies and procedures and her role and responsibilities. She provides support and oversight for enabler and restraint management with RN oversight.</p> <p>On the days of audit, there were no restraints in use and two enablers in use. The service has gradually reviewed and removed all bedrails by acquiring and using perimeter mattresses. The two residents using lap belts and/or bedrail were interviewed. They confirmed they secure themselves in their chairs with a lap belt and remove these when they choose. This was also the case with the bedrails for one resident, who has a lifelong physical disability. The use of enablers was clearly and accurately documented in their care records.</p>
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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 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>Information on the complaint process is provided to residents and families on admission. There are complaint forms and information about the right to complain on display in common areas.</p> <p>The complaint register records three complaints received since the previous audit. The only complaint acknowledged in writing was from the same complainant, concerned that their first complaint had not been acknowledged. In each case there was limited or no evidence of investigation and no written record that that matter had been resolved.</p> <p>Complaints are not being managed according to the documented policy and procedures.</p>	Complaints are not being managed according to the documented policy and procedures.	<p>Ensure that complaint processes are followed as per policy.</p> <p>90 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 2018 quality plan was not reviewed and there has been no goal focused quality plan in 2019 to guide service performance measurement. There are some methods for measuring achievement by comparing the year by year results of satisfaction surveys and the outcomes of internal audits.</p> <p>The senior RN coordinates a wide range of internal audits that are undertaken over a two-month period each year and all staff are allocated areas to assess and report on. The outcomes from these are collated, documented and reported back to staff. Review of the audit tools identified that many of these do not reliably identify best known practice, contractual requirements, the policies and/or the requirements of these standards. The audits are not reliably identifying service gaps or maintaining best practice. The processes in place have been used for a number of years.</p>	<p>There is no current quality plan.</p> <p>The internal audit system is failing to identify issues and/or gaps in service delivery.</p>	<p>Develop a goal focused quality plan as required in the ARC contract.</p> <p>Review the internal audit tools and system and implement actions to improve the effectiveness of audits.</p> <p>60 days</p>
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	<p>PA Moderate</p>	<p>Review of residents' files and staff interview revealed that a facility acquired Pressure Injury (PI) had not been reported to the Director General as required by Section 31 of the Health and Disability Services (Safety) Act 2011. The development of a PI was first noted on a long stay resident in August 2018. The wound continued to worsen eventually requiring assessment by the DHB wound nurse specialist in 23 January 2019 who confirmed the PI was Stage 3-4. The resident was admitted to Waikato hospital.</p>	<p>A stage 4 pressure injury was not notified to the DHB or the Ministry of Health as required under Section 31.</p>	<p>Ensure that essential notifications are reported according to Ministry of Health guidelines and Section 31 requirements.</p> <p>60 days</p>

		The provider had previously been reminded about Section 31 reporting during the August 2018 surveillance audit.		
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>The annual education plan provides all staff with regular education which is relevant to their roles.</p> <p>Absence of performance appraisals was a finding at the previous audit. The staff files reviewed showed that all care staff and RNs have engaged in an appraisal, but the nurse manager and senior RN have not had a performance appraisal since 2013.</p>	<p>The two people with the ultimate responsibility for clinical care and service leadership have not had any formal feedback on their performance.</p>	<p>Ensure the senior RN and nurse manager are provided the opportunity for performance feedback and performance goal setting.</p> <p>90 days</p>
<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 Low</p>	<p>The medication electronic device showed that for two residents their three-monthly GP review was not up to date. Staff interviewed stated that both residents were well. The two residents were booked at the time of audit to see the GP at their next visit.</p>	<p>Two residents' three monthly GP reviews booked for June and July are overdue.</p>	<p>Ensure that all GP reviews are up to date.</p> <p>90 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Moderate</p>	<p>Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process. All residents have individual initial care plans and long-term care plans. Residents have an interRAI assessment completed by one trained</p>	<p>InterRAI assessments are not being completed before the long-term care plans are developed nor do they identify all the needs of the resident.</p>	<p>Ensure that issues identified during the assessment process are used to inform the long-term care plans.</p>

		interRAI assessor on site. On the day of audit six of six files reviewed identified that the residents' long term care plans were completed prior to the interRAI assessment and the needs and outcomes of the resident were not always documented in the interRAI (see also criterion 1.3.5.2).		180 days
<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>	<p>PA</p> <p>Moderate</p>	<p>All residents have individual initial care plans and long-term care plans. Residents have an interRAI assessment completed by the one trained interRAI assessor on site. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process. On the day of audit, six of six files reviewed did not have all interventions required documented in the resident's long-term care plans and interRAI assessments.</p> <p>Three residents self-administering medications were not identified in the long-term care plan and/or interRAI.</p> <p>A resident who has a chronic condition requiring alternative daily interventions and support with medical provisions does not have identified acceptable outcomes, interventions, or parameters documented to support the cares required for the medical provisions and/or procedures in the long-term care plan or interRAI.</p> <p>One resident seen by the speech language therapist in April 2019 did not have their nutritional profile or long-term care plan</p>	<p>Six of six residents' long term care plans reviewed lacked the required detail and did not highlight all of the residents' needs and/or did not contain the information/presenting issues identified by the referrers.</p>	<p>Ensure that care plans reflect the needs and care required identified by the referrer and the assessment process.</p> <p>90 days</p>

		<p>updated. The resident's interRAI highlighted nine food restrictions but the nutritional profile stated 'numerous' and this information was also not reflected in the long-term care plan.</p> <p>One resident due to a chronic medical history requiring a fluid restriction and weekly weighs did not have this information documented in the resident's long-term care plan or interRAI assessment. There was no fluid balance chart.</p> <p>One resident who has long standing medical provisions and support required was admitted for respite care while recovering from surgery. Not all interventions required to support the resident with both long term and interim needs were highlighted in the long-term care plan, including catheter care, monitoring of skin integrity, the incision wound, personal cares and support with mobility and transfers.</p> <p>Two residents who affiliate with their culture had this information identified in their initial assessments on admission and activities assessment; however, their day to day interventions were not documented in the activities, long term care plan, nutritional profile or interRAI to show that the residents family members often brings in meals and the specific activities and care provided for the residents to meet their individual cultural needs.</p> <p>One resident had eight infections since admission, but this was not identified in the long-term care plan and/or interRAI.</p>		
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<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>The three oxygen concentrators are overdue for inspection. These were dated as due in February and May 2018. The chair scales have not been inspected for safety or calibrated for at least two years. Other medical equipment (otoscope, thermometers) area also overdue since the usual tradesperson who checked these ceased trade in 2017 and the operator has not sourced another agency/tradesperson. The sphygmomanometer is recording accurately as it was recently purchased.</p>	<p>Bio medical equipment is not being checked, calibrated (if required) or regularly maintained.</p>	<p>Ensure that all medical equipment is regularly tested and/or calibrated for accuracy.</p> <p>60 days</p>
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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.

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End of the report.