

# Papatoetoe Residential Care Limited - Papatoetoe Residential Care

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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 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>	Papatoetoe Residential Care Limited	
<b>Premises audited:</b>	Papatoetoe Residential Care	
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 5 November 2019	End date: 5 November 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

Papatoetoe Residential Care provides care for up to 30 residents requiring aged related rest home and hospital level care.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board (DHB). The audit process included the review of policies, procedures, residents' and staff files, observations and interviews with residents, family members, a general practitioner, the executive director (owner), managers and staff.

There were five areas requiring improvements from the previous certification audit in April 2018. The areas related to linking key aspects of service with the quality management programme, staff education, wound and pressure injury documentation, staff medicine competency training, and resident self-administration of medicine processes have been addressed. At this audit, there are five areas identified as requiring improvement related to complaints management, incident reporting, orientation records, and documenting and registering a food safety programme. Some residents are overdue their interRAI assessments.

## Consumer rights

<p>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.</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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Staff and management are adhering to the principles and practises of open disclosure. Access to interpreters and support for residents who have barriers to communication are available.

Information on the complaints process is available to residents and family members.

## Organisational management

<p>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.</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 organisation's philosophy, mission and vision statement are documented, along with goals. The executive director (who is one of the facility owners), the facility manager and the clinical nurse leader work together to ensure service planning covers all aspects of service. The services offered meet residents' needs, and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include having policies and procedures available to guide staff practices, an internal audit programme, incident/accident reporting, hazard and risk management, resident satisfaction surveys, and regular resident and staff meetings.

New staff are provided with an orientation. Ongoing education is provided at least monthly and records of attendance were maintained. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that their needs are met. The service has a documented rationale for staffing which is implemented. There is always a registered nurse on site .

## 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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The service is coordinated in a manner that promotes continuity and promotes a team approach to care delivery. There are policies in place to support assessment, planning, provision of care, evaluation and exit from the service and these meet contractual requirements. Individualised care plans are developed and implemented. When there are changes to the residents' needs a short-term plan is developed and this was integrated into a long-term plan, as needed. All care plans were evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There was a current building warrant of fitness. There have been no changes to the approved fire evacuation plan.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No residents had restraints in use. One resident was using an enabler. The use of restraints and enablers is monitored. Staff are provided with relevant training.

## 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.

Surveillance for infections occurs with relevant data and information completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infections. The infection surveillance results are reported to staff and residents, where appropriate.

## 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	12	0	2	3	0	0
<b>Criteria</b>	0	35	0	2	3	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Concern / complaint forms and compliment forms are available in the main entrance. The complaint process is described in the residential agreement and in the information pack given to residents/family members on or prior to admission.</p> <p>The facility manager is responsible for complaints management, with the support from the Executive Director. Staff interviewed demonstrated a good understanding of the complaint process and what actions are required from them.</p> <p>The service does not have a complaints register. The two complaints received from the Health and Disability Commissioned are not present or referenced in the complaints folder, and records were not available to demonstrate the response to two complaints received earlier in 2019.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>FA</p>	<p>The service provider understands the principles of open disclosure, which are described in policy. Family members stated they were kept informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and the outcomes of regular and any urgent medical reviews. This was confirmed by the information reviewed in residents' records and incident reports sampled.</p> <p>Staff knew where and how to access interpreter services if needed to communicate with non-English speaking residents, but this has not been required recently. There are three residents that cannot effectively communicate in</p>

<p>provide an environment conducive to effective communication.</p>		<p>English. There are staff employed who can communicate with the residents in their first language.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Papatoetoe Residential Care Ltd has a documented mission statement, philosophy and values that is focused around the provision of individualised, quality care where residents' independence is maintained along with respect, privacy and dignity. Freedom of choice is promoted, and individual resident's needs are identified and met with the intent of enhancing each resident's quality of life. The 2019-2020 business plan details seven specific objectives.</p> <p>The executive director is one of the two business owners. The executive director is a chartered accountant and has owned this rest home since June 2011. The executive director has been on site for at least three days every three weeks or more frequently if required. The executive director is available by phone, text and email when not on site and confirmed being in communication with the facility manager or clinical manager on almost a daily basis. The management team monitors the progress in achieving goals via day to day activities, resident / family feedback and monitoring of the results of quality and risk activities.</p> <p>Delegations of authority are documented, and these include the executive director having approval of policy and procedure changes. The executive director is responsible for any external notifications. The executive director is a member of the board of directors of a large regional health service.</p> <p>The facility manager has been in the role since July 2017 (prior to the last audit) and works four weekdays a week. The facility manager trained as a registered nurse and has held management roles in other aged related residential care services; however, no longer maintains an annual practising certificate (APC). The facility manager is responsible for the day to day operations, while ensuring the care and wellbeing of residents is the responsibility of the clinical nurse leader. The facility manager participates in relevant ongoing education as required to meet the provider's contract with Counties Manukau District Health Board (CMDHB).</p> <p>The clinical nurse leader (CNL) was employed in this role prior to the last audit and works full time. The CNL is responsible for providing oversight of residents clinical and personal care. The CNL shares on call with another senior nurse, each rotating and having two weeks on call and then two weeks off call. The CNL has a current interRAI competency, and current annual practising certificate.</p> <p>The service has a contract with CMDHB for the provision of aged related (ARRC) rest home and hospital (continuing) level care, as well as a contract for the provision of long term support (chronic care conditions) - LTS-CHC. A contract with the Ministry of Health (MOH) for residential non aged care is also in place and includes respite services. There was one resident under the age of 65 years receiving care under the MOH contract at hospital level care. One resident is funded by Accident Compensation Corporation (ACC) at hospital level care. One resident is receiving services under LTS-CHC contract at hospital level of care. There are four residents receiving rest home level care and 17 residents receiving hospital level care under the ARRC contract. This includes one resident receiving respite care, and one resident who was receiving services under the oversight of the DHB mental health</p>

		service.
<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 continuous quality improvement principles.</p>	FA	<p>Papatoetoe Residential Care Ltd has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, complaints and compliments reporting, health and safety reporting, hazard management, infection control data collection, restraint minimisation, staff education and regular staff meetings. Regular internal audits are conducted and the results of six audits sampled at random from the internal audit calendar demonstrated a high level of compliance with organisational policy. If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective action plans were documented for applicable events and implemented, with the exceptions as noted in criteria 1.1.13.3 and 1.2.4.3. Quality information is shared with all staff via shift handover as well as via the monthly staff meetings. The staff meetings minutes now included infection / surveillance data and the information on the use of restraint and enablers; this now meets the standards. Staff meeting minutes included an area to follow up on matters raised at the last meeting.</p> <p>Meetings are held every month with residents to obtain feedback on services, food, and activities as well as obtain information for future planning. The minutes of the last three residents' meetings were sighted. The results of the residents' satisfaction survey (May 2019) included asking residents and families to provide feedback on at least eight different aspects of service. The feedback from the five respondents to the satisfaction survey was positive.</p> <p>The hazard register was sighted, and new hazards identified, reported and mitigated. This included maintenance issues which have been addressed. The Health and Safety Committee meets monthly and outcomes / issues then discussed at the staff meeting. Staff interviewed understood their responsibilities to communicate any new hazards. The health and safety representative interviewed confirmed staff were proactive in reporting applicable events.</p> <p>Policies or standard operating procedures (SOP) were readily available for staff. Some policies have been developed by an external consultant and localised to reflect the needs of the facility. Other policies / SOPs have been developed by Papatoetoe Residential Care Ltd. A paper copy of policy manuals was available for staff. An index in each of the manuals details when the policies are due for review. The approval process includes the executive director reviewing any amendments and approving the documents before release. The management team are currently working to review the policies and procedures, with service delivery policies, and human resources documents reviewed and updated first. The administrator is responsible for document control processes.</p> <p>Actual and potential risks are documented and reviewed. Mitigation strategies have been documented. The executive director confirmed being in frequent communication with the management team and being kept informed of quality and risk issues as they emerge.</p> <p>Staff, resident and family interviewed expressed a high level of satisfaction about the services provided at Papatoetoe Residential Care Ltd.</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 Low</p>	<p>A standard operating procedure details the required process for reporting incidents and accidents. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and ongoing education. Incidents are discussed at staff meetings.</p> <p>Applicable events are being reported in a timely manner and disclosed with the resident and/or designated next of kin. This was verified by all family members interviewed and communications documented in residents' records sampled. Copies of some incident reports sighted, held centrally inadvertently contain information about other reported events / residents. While the actions taken in response to some reported events were clearly detailed, this was not consistent</p> <p>The executive director advised essential notifications have been made in relation to the decision to 'trespass' two residents' family members. The DHB portfolio manager was aware of these events as noted in information provided prior to the audit. The facility manager reported liaising with the DHB portfolio manager to seek advice about responding to two complaints. The executive director and the facility manager detailed the other types of events that require notification. The service has long standing RN vacancies (refer to 1.2.8 and 1.3.3.3), with some shifts currently being covered by agency / bureau staff. A section 31 notification has not been made in relation to registered nurse staffing as all applicable RN shifts have been covered to date. The executive director has recently become aware of the section 31 notification requirements related to RN workforce / recruitment issues and is collating data to inform a notification report to the Ministry of Health. There have been no events requiring reporting to the Coroner, and no outbreaks of infection.</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 Moderate</p>	<p>Copies of the annual practising certificates (APCs) were sighted for the two general practitioners (GPs), the dietitian, the 16 pharmacists, the podiatrist, the physiotherapist and the CNL and other registered nurses (RNs).</p> <p>Recruitment processes include completing an application form, conducting interviews and reference checks. Police vetting is occurring for new staff at employment. Staff have a job description on file. The job description / employment contract and confidentiality documents include a statement advising staff of privacy / confidentiality requirements. Performance appraisals have occurred for staff files sampled within the last 12 months or were in progress, with records sighted of those currently in progress.</p> <p>A staff education programme is in place with in-service education provided monthly and topics align with the provider's contractual requirements and included restraint minimisation / use of enablers, abuse and neglect and pressure area prevention / management. This now meets the standards. Records of attendance at education are being maintained. Staff attend in-service education on site and can attend external education opportunities.</p> <p>Staff advised they are provided with an orientation relevant to their role, however records of completion were not being consistently maintained. Bureau / agency RNs are given a verbal orientation / induction; however, records are</p>

		<p>not retained of what is covered. These are areas requiring improvement.</p> <p>Applicable staff are required to have medicine competency. The RN's administer the medicines and caregivers are trained as a 'second checker'. The staff competencies were in the process of being revalidated as at audit. All except four caregivers have completed this training. These caregivers were not involved with medicine checking. The employed RNs have current competencies including for 'Nicki T' pump management. The shortfall raised at the last audit in criterion 1.3.12.3 has been addressed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy details staffing levels and skill mix requirements, and this aligns with the requirements of the provider's contract with Counties Manukau District Health Board (CMDHB). The staffing framework was reviewed in 2019.</p> <p>At the time of audit, there were 1.5 full time equivalent (FTE) registered nurse vacancies and 1.5 FTE casual caregiver vacancies. There are three full time and one part time RNs employed. A new nurse was recruited to commence work starting late October 2019; however, this did not proceed. One caregiver is returning from long term leave the week following audit. Bureau/agency nurses were being utilised to cover shifts and records were retained to demonstrate this. In October 2019, sixteen RN shifts were covered by a bureau/agency RN, with this occurring for two afternoon shifts and fourteen night shifts, where the bureau/agency RN was one of two personnel on duty. On other occasions the employed RN or CNL may work extra or longer hours to cover a shift. The service has contracts with three external agencies for the provision of staff when required. Refer to 1.2.7.4 related to orientation of bureau/agency nurses. The bureau confirmed all RNs provided have a current APC, first aid certificate, and are provided with training on and have to create their own unique logon to the electronic medicine management system. The CNL, executive director and the RN interviewed advised there is always an RN on duty.</p> <p>The CNL and one other RN have interRAI competency. With the current RN vacancies, the RNs have focused on providing the required clinical care to residents. As a result, some resident interRAI assessments are overdue (refer to 1.3.3.3).</p> <p>The current roster and the previous roster was reviewed. Staffing aligns with policy. Each roster issued contains the RN and housekeeping services roster for a two week period. Caregivers' rosters are issued weekly. Where there are changes in hours worked or staffing is different to that noted on the roster, these changes are recorded on the roster. The rosters sighted demonstrated that there is a registered nurse on duty every shift.</p> <p>The clinical nurse leader and a senior RN share being 'on call' rotating week about. All registered nurses including the CNL have a current first aid certificate.</p> <p>The facility manager advised most of the caregivers have an industry approved qualification or equivalent due to the length of time they have worked providing care in the aged residential care setting. One of the caregivers interviewed has been working in this facility for 26 years.</p> <p>Five caregivers are rostered on morning shifts with finish times staggered between 12.45 pm and 3 pm. Three</p>

		<p>caregivers are rostered on the afternoon shift starting at 3 pm with finishing times varying between 9 pm and 11 pm. There is a minimum of two staff on site overnight from 10.45 pm or 11 pm to 7 am. This comprises a RN and one caregiver.</p> <p>A cleaner is rostered six hours each day Monday to Friday, and a cleaner works two hours on both weekend days. The activities coordinator works 9 am to 5 pm Monday to Friday. The activities coordinator has a current first aid certificate. A cook is rostered for eight hours a day seven days a week. Three staff share the cooking roster. A kitchen hand is rostered 7am to 3pm each day. The person responsible for maintenance / gardening works two mornings a week. All laundry is outsourced to a commercial laundry service. An administrator works weekdays. The executive director assists with this role when the administrator is on leave.</p> <p>Residents and the family member interviewed confirmed their personal and other care needs are being met. Residents verified their call bells are answered in a timely manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>A safe system for medicine management using an electronic medicine management 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 were competent to perform the function they manage (refer to 1.2.7).</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. A medication competent staff member checks medication 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 controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The clinical pharmacist last completed a full medication pharmacy check in August 2019; no corrective actions were required.</p> <p>The records of temperatures for the medicine fridge reviewed were within the recommended range. The medication room temperature was also monitored.</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 were consistently recorded on the electronic medicine management system. Standing orders were not used. Vaccines were not stored on site.</p> <p>There was one resident who was self-administering medication at the time of audit. Appropriate processes including a locked drawer for storage and three monthly self-medication reviews by the registered nurse and general practitioner were in place to ensure this was managed safely. The shortfalls raised at the last audit in criteria 1.3.12.3 and 1.3.12.5 have been addressed.</p>

		There was an implemented process for comprehensive analysis of any 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>	PA Low	<p>The food service is provided on site by three cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in March 2019. Recommendations made at that time have been implemented.</p> <p>The service has yet to document a food safety plan and have this verified. Food temperatures, including for high risk items, are monitored appropriately and recorded. The cooks have 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 developed. The personal food preferences including cultural aspects, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessments tools such as a pain scale, falls risk, continence, skin integrity, and nutritional screening, as means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. Five out of 23 interRAI assessments were overdue (see criterion 1.3.3.3).</p> <p>The files audited had evidence of wound management, such as a wound care plan and evaluation. Evidence of wound assessments including photographs of chronic wounds were sighted. Staff interviewed confirmed that they understand the pressure injury management process and equipment, such as air mattress and pressure relieving cushions, were in use for residents who were at risk of developing a pressure injury. The shortfall raised at the last audit in criterion 1.3.4.2 has been addressed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is delivered according to instructions.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. A range of equipment including air mattresses, pressure relieving cushions and other resources were available in accordance with the residents' needs. On the day of audit, no active pressure injuries were reported and care staff demonstrated knowledge in pressure injury management.</p>

desired outcomes.		
<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 an experienced activities coordinator and supports the residents at Papatoetoe Residential Care 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 daily and as part of the formal six-monthly care plan review. The facility encourages residents to be involved in community groups and events and day to day activities of living that support their cultural and spiritual needs, their interests and their age.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included 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 residents' meetings. Residents interviewed confirmed they find the programme meets their needs and that they look forward to going out.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</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. Care plan evaluations occur every six months in conjunction with the interRAI reassessment, or as residents' needs change. InterRAI assessments are required to be reviewed every six months, although not all reviews were up to date at the time of audit (see criterion 1.3.3.3). Where progress was different from expected, the service responded by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, wounds, continence, challenging behaviour and mobility. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness with an expiry date of 16 March 2010. There have been no changes to the approved fire evacuation plan. Ongoing maintenance and refurbishment of the facility is occurring as residents' rooms become vacant.</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>Surveillance is appropriate to that recommended for long term care facilities and included infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and ear, nose and throat (ENT). The infection prevention and control coordinator reviews all reported infections, and these were documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data was collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. An internal benchmarking process is in place. The infection rates in the facility are low.</p> <p>There has been no occurrence of infection outbreaks since the previous audit.</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>The organisation has policies and procedures related to safe restraint practices. There was one enabler in use at the time of audit (refer to 1.3.3). No restraints were in use. Policy identifies that the use of enablers is voluntary for the safety of residents in response to individual requests. Use of enablers and restraints was monitored monthly. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes. Staff have been provided with training on restraint minimisation and use of enablers.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>A complaints register is no longer being maintained as verified by interview with the facility manager. Complaints received are placed in a designated folder. This does not include all complaints. There have been two complaints received via the Health and Disability Commissioner since the last audit. One complaint was also sent by the complainant to other governmental agencies/authorities. The service has provided a response to the HDC complaint received in June 2019. There was no information related to this complaint in the complaints folder. The complaint and response documents were being stored in with other resident records. The complaint received by the HDC in October 2019 has been referred to Papatoetoe Residential Care for direct management and response to the complainant by a designated date. The facility manager has been unable to contact the complainant despite multiple attempts. While the facility manager could detail the interventions that had been taken in response to two other complaints received earlier in 2019, records related to the acknowledgment, investigation and response could not be located during audit.</p>	<p>A complaints register is not being maintained. Two complaints are not present or referenced in the complaints folder. All records related to the responses for two other complaints could not be located.</p>	<p>Maintain a complaint register that includes details of all complaints. Accessible records are available that demonstrate all stages of the complaint management process and that timeframes align with the</p>

				Code of Health and Disability Services Consumers' Rights (the Code).  90 days
<p>Criterion 1.2.4.3</p> <p>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.</p>	PA Low	<p>A review of reported events including falls, skin tears, a pressure injury present on admission, medicine errors, challenging behaviour, breach of a resident's privacy by a resident's family member, and a staff needle stick injury demonstrated that incident reports are completed in a timely manner. Wound care plans are developed and monitored for residents with wounds. The reverse of the form includes an area to identify the outcome of the investigation and actions required to be taken to address the issue. The completed incident form is copied and placed in a centralised folder by the facility manager for quick reference and ongoing monitoring. The original incident form is filed in the applicable residents' record. Three of the eight incident forms sighted at random in the central folder held by the facility manager contained the outcome of the investigation and follow-up from a different event and resident (i.e. unrelated to the reported event). One of these three original incident reports that had been filed in a resident's file was located and reviewed. This related to a medication error by a bureau nurse. Several additional issues were noted on the reverse of the form as requiring follow-up. While the facility manager described the interventions that had occurred in response to this event including the additional issues noted, none of these actions were documented on the original incident form or in other records sighted. The investigation and actions for the other five events were documented and followed up appropriately.</p> <p>Staff communicated incidents and events to oncoming staff via the shift handover. A summary of reported events was discussed with staff at the staff meetings as verified by staff interviewed and noted in meeting minutes.</p>	<p>The copies of three out of eight incident reports sampled at random, that are held in a centralised incident file, have investigations and follow up on the reverse of the reporting form that are unrelated to the reported event.</p> <p>Actions taken in response to a medicine error involving a bureau registered nurse were not documented.</p>	<p>Ensure that investigation and follow-up consistently occur for all reported events and that records are retained to demonstrate these processes relate to the correct reported event.</p> <p>90 days</p>
Criterion 1.2.7.4	PA	New employees are required to complete an orientation programme	Bureau/agency	Ensure new

<p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>Moderate</p>	<p>relevant to their role. A workbook is utilised to ensure all relevant topics are included. New employees are 'buddied' with senior staff for a number of shifts until the new employee is able to safely work on their own. The care staff confirmed the orientation suitably prepares new staff for their roles and responsibilities. Records were not present for two out of four staff whose records were sampled (employed since October 2017) to demonstrate that the staff have completed the Papatoetoe Residential Care Facilities orientation programme.</p> <p>Bureau/agency registered nurses are being used while the service works to recruit new RNs. The bureau/agency RNs are often on duty on the afternoon shift, or on a night shift where they are one of two personnel on duty (refer to 1.2.8). The employed RNs and CNL interviewed advised the bureau/agency RNs are given an orientation to the facility, environment, on call contact details and emergency procedures, and the electronic medicine management system used when they present for their first shift; however, records were not retained of this process.</p>	<p>registered nurses are being utilised to cover shifts. Records were not maintained to demonstrate their induction/orientation.</p> <p>Records were not available to demonstrate that two staff employed since October 2017 have completed the organisation's orientation programme.</p>	<p>employees and bureau/agency RNs are given and orientation or induction relevant to their role and that records are retained to demonstrate this.</p> <p>90 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>Food is checked for 'use by date' and damage when delivered, then stored in well organised and appropriately temperature-controlled storage. Fridge, freezer, and cooked meat temperatures are monitored daily. Records sighted verified temperatures were within accepted parameters. The service has yet to document a food safety plan and to have this verified.</p>	<p>A food safety plan has not been documented or registered with the applicable regulatory authority. A verification audit of the programme has not been undertaken as required by legislation.</p>	<p>Document a food safety plan and register this with an appropriate authority and have implementation of the programme verified by a third party as required.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p>	<p>PA</p>	<p>InterRAI assessments are completed by two interRAI trained nurses. The</p>	<p>The interRAI</p>	<p>Ensure that</p>

<p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>Moderate</p>	<p>residents' files reviewed have evidence of updated interRAI assessments, detailed care plans which are evaluated and updated at least six monthly. As per the interRAI assessment due list, five out of 23 interRAI assessments are overdue, with one assessment overdue by over seven months.</p>	<p>reassessments have not being completed six monthly for five out of 23 residents, with one of these overdue by over seven months.</p>	<p>interRAI reassessments are completed six monthly.  90 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.

No data to display
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End of the report.