North Care Limited - Lester Heights Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	NORTH CARE LIMITED
Premises audited:	LESTER HEIGHTS HOSPITAL
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 20 February 2020 End date: 21 February 2020

Proposed changes to current services (if any): Change of ownership and adding Hospital - Medical Services

Total beds occupied across all premises included in the audit on the first day of the audit: 31

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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
	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

Lester Heights Hospital provides care for up to 35 residents requiring rest home, hospital and residential disability – physical care. The facility is operated by Lester Heights Hospital Limited. The service is managed by the owner/manager and a clinical manager.

This provisional 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, management, staff, an advocate and a general practitioner.

This audit also established how well prepared the prospective provider is to provide a health and disability service. The prospective owner was interviewed during this audit. The prospective provider understands the Health and Disability Services Standards and the Age Related Residential Care Agreement. The appropriate person in the District Health Board has been advised of the change of ownership prior to the provisional audit.

Improvements required from this audit relate to the availability of a business plan, separate meetings for the younger residents with a physical disability, specific training relating to younger residents with a physical disability, evaluation of activity plans, accessing the community and regular outings, review of the menu, standard of cleanliness and maintenance internally, maintenance of the gardens including the provision of shade and the evaluation of restraint use.

Consumer rights

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

Residents and 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 provided support personal privacy, independence, individuality and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure residents and family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents.

The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. 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 residents' needs.

Residents and family members interviewed spoke very positively about the comfortable, relaxed environment and the care and support provided.

The owner/manager is responsible for the management of complaints and a complaints register was current. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

Lester Heights Hospital Limited is the governing body and is responsible for the service provided. Quality and risk management systems are fully implemented at Lester Heights Hospital. Systems are in place for monitoring the service, including regular meetings between by the owner/ manager and the clinical manager.

The facility is managed by an experienced owner/manager who has owned the facility for three and a half years. The owner/manager is supported by a clinical manager and the assistant manager/administrator. The clinical manager is responsible for the oversight of the clinical services.

Quality and risk management systems are followed. There is an internal audit programme. Adverse events are documented on accident/incident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff and resident meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks.

Policies and procedures on human resources management are in place and processes are followed. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are always rostered on duty. The clinical manager, registered nurses and the owner/manager are on call after hours.

Residents' information is kept safe, secure onsite and all entries are legible.

Continuum of service delivery

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

Service is provided in a manner that promotes continuity in service delivery and a team approach to care delivery. All processes for assessment, planning, provision, evaluation, review and exit are provided and completed by suitably qualified personnel. InterRAI assessments and individualised care plans are completed. When there are changes to the resident's needs, an acute/short-term plan is developed and integrated into a long-term support plan, as needed.

The service provides planned activities that meets the needs and interests of the residents as individuals and in group settings. Residents and family/whanau expressed satisfaction with the activities programme.

There was a safe electronic medicine management system. The medicine administration system was observed at the time of audit. Staff competency assessments are maintained. The GP completes three monthly reviews or more frequently as needed.

Food services meet the preferences of residents and special diets are catered for. There is a food control plan in place.

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

A current building warrant of fitness is displayed. Preventative and reactive maintenance programmes include equipment and electrical checks.

Single accommodation is provided. Rooms have a wash hand basin. Adequate numbers of bathrooms and toilets are available. There are lounges, dining areas and alcoves. External areas for sitting are provided.

An appropriate call bell system is maintained, and security and emergency systems were in place.

Protective equipment and clothing were provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems are audited for effectiveness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraint and enablers during the audit. Documentation was reviewed including a current restraint/enabler register.

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.

The infection control management system minimises the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. Documentation sighted evidenced that relevant infection control education is provided to staff.

Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	5	2	0	0
Criteria	0	93	0	7	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Lester Heights Hospital has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumer Rights (the Code). 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 and ongoing training is provided as verified in the training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files sampled showed that informed consent has been gained appropriately using the organisation's standard consent form. These were signed by the enduring power of attorney (EPOA) or residents and the general practitioner makes a clinically based decision on resuscitation authorisation if required. Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents interviewed were aware of the advocacy service, how to access this and their right to have support persons.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents have visitors of their choice who visit regularly, however access to the community and other mainstream supports was limited for all residents including young people with disability (refer 1.3.7.1). 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 encounters with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The owner/manager(O/M) is responsible for complaints management and follow up. The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and forms available at the entrance to the facility. The complaints register showed six complaints have been received since the previous audit. Actions taken, through to an agreed resolution were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required. The O/M reported there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The prospective owner demonstrated a sound understanding of The Code. Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family members and residents interviewed were aware of consumers' rights and confirmed that information was provided to them during the admission process.

		The information pack outlines the services provided. Resident agreements signed either by the resident or by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.
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.	FA	Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity. The residents' privacy and dignity were respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with residents assessed as rest home level of care, hospital level of care and young people with disabilities able to move freely into the surrounding areas and in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural values, religious beliefs and social needs, had been identified, documented and incorporated into their care plan. There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The clinical manager (CM) reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. The GP reiterated that there was no evidence of any abuse or neglect reported. Family/whanau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The required policies on cultural appropriateness were documented. Policies refer to the Treaty of Waitangi and partnership principles. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identified barriers to access. It also recognised the importance of whanau. Assessments and care plans documented any cultural/spiritual needs. Special consideration of cultural needs is provided in the event of death as outlined in the policy. The required activities and blessings are conducted when and as required. There is a Maori volunteer who comes regularly to meet with all Maori residents. The menu confirmed that 'boil ups' are provided as needed. Staff have received cultural awareness training. There were residents who identified as Maori at the time of the audit.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they were

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		encouraged to be involved in the development of the long-term support care plans. Residents' personal preferences and special needs were included in care plans sampled.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and this was confirmed by the residents. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. 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. The clinical manager (CM) and lead RN stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through ongoing professional development of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. There were staff who were in the process of completing Careerforce level three and four training. The service also provides placements and support for the Competency Assessment Programme (CAP) for overseas registered nurses, some of whom were onsite on the days of the audit. Policies and procedures are linked to evidence-based practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Family members stated they were kept well informed about any changes to their relative's health 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 sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures. Staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards is encouraged. There was a young person with disability with impaired hearing. Staff were observed communicating with a resident who had impaired hearing using written communication on a note pad. The young person with a disability (YPD) was able to lip read and hear when staff speak loudly and slowly. Strategies to promote effective communication were documented. It is suggested that it would be beneficial for some staff and some of the peer group if they wished, to learn some NZ sign language to support

		the person with their communication. Deaf awareness/taster class training to manage effective communication with a resident with impaired hearing was provided on 8 May 2018 and 11 staff attended (refer 1.2.7.5).
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low	Lester Heights Hospital Limited is responsible for the services provided. A business plan was not available apart from eight goals that are reviewed quarterly. The O/M has owned the facility for three and a half years and has a background in marketing and management. The management of clinical services is the responsibility of the clinical manager (CM) and lead RN who are both experienced in aged care. The annual practising certificates for the clinical manager and lead RN were current. There was evidence of appropriate ongoing education for the O/M, CM and lead RN. Weekly meetings are held between the O/M and CM. Minutes reviewed evidenced various activities concerning the facility are discussed. The prospective owner stated meetings will continue with the CM. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service. It includes younger people with a physical disability. The prospective provider, North Care Limited, consists of one owner. The prospective owner, who is an RN currently owns and manages another facility and has done so for three years. Prior to the current situation the prospective owner managed another aged care facility for four years. A comprehensive transition plan reviewed, and interview of the prospective owner and the current owners evidenced the current owners are committed to providing a comprehensive handover during the transition period until the 1 April 2020 when the prospective provider take ownership. The prospective owner's business plan and quality and risk plan was also reviewed. The senior management team will remain in place and existing staff will transfer to the new provider. The prospective owner will provide support to the management and clinical team. The current owner reported they have notified the District Health Board prior to the provisional audit being undertaken. The prospective owner reported they plan to liaise with the District health Board following the audit. Occupancy on the first day of the audit totalled 31 residents, 19 residents assessed as hospital and rest home level (eight rest home and 11 hospital level under the 'Aged Related Residential Care Contract) and two hospital level care under the 'Long Term Support-Chronic Health Conditions' contracts with the DHB. Ten residents were under the age of 65 years with a physical disability

		under a 'Residential Non-Aged – YPD' contract with the MoH. The provider had adequate resources such as hospital beds and trained staff to meet the needs of the residents requiring hospital (medical) services. The O/M reported 12 of the larger rooms have been approved as dual-purpose rooms.
Standard 1.2.2: Service Management 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.	FA	When the O/M is absent, the CM fills the role with support from the assistant manager. When the CM is absent, the lead RN is responsible for the clinical service. The prospective owner is not planning any immediate changes. Existing cover arrangements for the day to day operation will be reviewed within 12 months. The prospective owner understood the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	A quality improvement and risk management plan guides the quality programme and includes a mission, quality commitment, objectives and quality principles. An internal audit programme is in place and audits completed for 2019 and 2020 were reviewed, along with processes for identification of risks. Monthly staff meetings include quality, health and safety, restraint and infection prevention and control. Registered nurse meetings are held prior to the full staff meeting. Meeting minutes, including quality data, are available in the nurses' station for staff to read and sign off. Meeting minutes evidenced reporting of completed internal audits, quality data, including clinical indicators which are graphed. Resident meetings are held three monthly and included topics of interest. Separate meetings are not held for the younger residents with a physical disability and they reported there was no recognition or discussion of their different needs. Younger residents with physical disabilities expressed satisfaction with regards to making decisions. Younger residents live throughout the facility and reported this is their choice rather than being all together. They have electronic equipment and some aids to help mobility and independence. Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed. There was documented evidence quality improvement data is being collected, collated, analysed and reported. Quality improvement data included adverse event forms, internal audits, meeting minutes satisfaction surveys, infection rates and health and safety. Corrective action plans are being developed, implemented, monitored and signed off as being completed. Relevant standards are identified and included in the policies and procedures manuals. Policies

		and procedures reviewed were relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed they were advised of updated policies and that they provided appropriate guidance for service delivery. Obsolete documentation both electronic and hard copy are archived. A Health and Safety Manual is available that includes relevant policies and procedures. Actual and potential risks are identified associated with human resources management, legislative compliance, contractual and clinical risk. The hazard register identifies hazards and evidenced the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. A senior health care assistant (HCA) is the health and safety coordinator and is responsible for hazards. The HCA demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes. The prospective provider advised the current policies and procedures and the quality and risk management plan will remain the same and be reviewed within the first 12 months with the introduction of an electronic system.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Staff are documenting adverse, unplanned or untoward events on an accident/incident form including completing neurological observations and falls risk assessments completed following accidents/incidents as appropriate. These are collated by the CM and documentation reviewed and interviews with staff indicated appropriate management of adverse events. There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. The satisfaction surveys confirmed this. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The O/M advised there have been six essential notifications made to HealthCERT and the DHB since the previous audit. Review of the Section 31s confirmed this. There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, training certificates and police vetting. An orientation/induction programme is in place and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, can take up to two weeks to complete depending on prior experience and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers all essential components of the service provided. The inservice programme was reviewed for 2019 and 2020. In-service education is provided for staff prior to each staff meeting and shift handover including specific topics relating to resident's health status. Registered nurses and HCAs are encouraged to attend sessions provided by the local DHB. Individual records of education are held and were reviewed. Current competencies were sighted including but not limited to medicines and restraint. Attendance records are maintained. Three RNs are interRAI trained and have current competencies including the CM. Specific training relating to younger people with a disability has not been provided to staff since 2018. A New Zealand Qualification Authority education programme is available for staff to complete and they are encouraged to do so. Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice. Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. All the RNs are experienced in aged care. Rostering is the responsibility of the O/M and the CM. The O/M reported they review the rosters weekly and consider dependency levels of residents and the physical environment. The CM works full time Monday to Fridays. One RN and five HCAs are rostered on the morning shift. All start their shift at 6.50am and have different finishing times. One RN and four HCAs are rostered on the afternoon shift with one HCA from the morning shift working until 5pm. One RN and one HCA are on the night shift. There are dedicated cleaners and laundry staff. The O/M is on call for non-clinical issues and the CM and RNs are rostered on-call after hours for

		clinical matters. Staff reported there are adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided. The prospective owner intends to maintain the current staffing levels and skill mix. The prospective owner stated the staffing policy will remain in place initially and be reviewed within 12 months. The prospective owner understood the required skill mix to ensure hospital, rest home and YPD residents needs are met.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	A resident register is maintained of all current and past residents. Residents' individual information is kept in paper and electronic format. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with the GP and allied health service provider notes. Written records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	All assessments are completed by suitably qualified personnel prior to entry. The assessment documents are a pre-requisite before admission. Lester Heights Hospital's welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the residents, family/whanau where appropriate, local communities and referral agencies. Records sampled confirmed that admission requirements were conducted within the required time frames and signed on entry. Family/whanau and residents interviewed confirmed that they received sufficient information regarding the services to be provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and	FA	There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or

coordinated transition, exit, discharge, or transfer from services.		discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There is a documented policy on the management of the medication system. All medication entries sampled confirmed that they were reviewed as required. Allergies were documented, identification photos were present and three-monthly reviews were completed. The lead RN was observed administering medication correctly. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from hospital, for new admission or when there are any medication changes. The service uses pharmacy pre-packed packs that are checked by the RNs on delivery. The controlled drug register was current and correct. Weekly, monthly and six-monthly stock takes were conducted, and all medications were stored appropriately. Medication audits were conducted, and corrective actions have been acted on. Monitoring of medication fridge and room temperature was maintained. There were no residents self-administering medication and there is a policy and procedure for self-administration of medication if required. Self- administration of medicines is encouraged for YPD residents who wish to do so if appropriate. An annual medication competency is completed for all staff administering medications and medication training records were sighted. The medicines management system complies with legislation, protocols and guidelines.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low	Residents' food preferences are developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements were provided to residents with identified weight loss issues. Snacks and drinks are available for residents as and when required. The family members and residents interviewed acknowledged satisfaction with the food service. All food services staff have completed training in food safety/hygiene. The kitchen and pantry were clean, tidy and well stocked. Labels and dates were on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is

		conducted. The menu was not reviewed by the registered dietitian in a timely manner.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The clinical manager (CM) reported that all residents who are declined entry are noted. When a resident is declined entry, family/whanau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents had their level of care identified through a needs assessment by the assessment agency. Initial nursing assessments were completed within the required time frame on admission while residents' care plans and interRAI assessments were completed within three weeks according to policy. Assessments and care plans were detailed and included input from the family/whanau, residents and other health team members as appropriate. Additional assessments were completed when needed; this included pain, behavioural, falls risk, nutritional requirements, continence, skin and pressure injury assessments. The nursing staff utilised standardised risk assessment tools on admission. In interviews conducted, family/whanau and residents expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment findings in consultation with the resident and/or family/whanau, inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Acute/short term care plans were used for short-term needs. Family/whanau and residents interviewed confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, disability services, district nurses, physiotherapist, podiatrist, dietitian and GP.
Standard 1.3.6: Service Delivery/Interventions	FA	Interventions were adequate to address the identified needs in the care plans. Significant changes were reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. The GP reported that medical input was sought in a timely manner, that medical orders are

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		followed, and care is person centred. Care staff confirmed that care was provided as outlined in the care plan.
Standard 1.3.7: Planned Activities 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.	PA Moderate	Lester Heights Hospital has an activity programme in place that covers rest home, hospital and YPD residents. Over the course of the audit, residents were observed being actively involved in a variety of activities. Activities are modified according to abilities and cognitive function. Residents and family members interviewed reported that a variety of activities were provided but regular outings/drives could be improved. An improvement is required to ensure activity plans are reviewed in a timely manner and regular outings are conducted.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care was documented on each shift by care staff in the progress notes. The registered nurses completed progress notes on every shift and care staff completed a tick chart for all activities of daily living. All noted changes by the care staff were reported to the RNs in a timely manner. Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals, occur every six months or as a resident's needs change. Activities plans were not reviewed along with interRAI assessments (refer 1.3.7.1). Evaluation/reviews were carried out by the RNs in conjunction with family, GP and specialist service providers. Where progress was different from expected, the service was seen to respond by initiating changes to the service delivery plan. Acute/short term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau were included and informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided	FA	Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers where required. If the need for other non-urgent services are indicated or requested, the GP and the nursing team sends a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses or the GP. The resident and the family were kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals were attended to and the resident transferred to the public hospital in an ambulance if required.

to meet consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances were in place. Incidents are reported in a timely manner. Safety data sheets were sighted throughout the facility and accessible for staff. The hazard register was current. Protective clothing and equipment were sighted in the sluice rooms and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed understood processes relating to the management of waste and hazardous substances.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate	A current building warrant of fitness was displayed that expires 1 December 2020. The internal environment requires maintenance with surfaces throughout the facility having been damaged and in need of painting and protection. The outside of the building is maintained to an adequate standard. Cleaning of the facility was not to an acceptable standard. Residents confirmed they can move freely around the facility and that the accommodation meets their needs. There is a proactive and reactive maintenance programme in place. Maintenance is undertaken by the O/M. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. There are external areas available, mainly at the front of the facility that are maintained to an adequate standard. However, the raised gardens around the back are full of weeds and look unkept. There is no shade for residents who venture outside. The external areas do not encourage residents to enjoy the outside and residents confirmed this. Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it. The facility is accessible to meet most of the mobility and equipment needs of people receiving services. The prospective owner stated there are currently no plans for any environmental changes to the facility, apart from general maintenance.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with	FA	Bedrooms offer single accommodation and have wash hand basins. There are adequate numbers of bathrooms and toilets throughout the facility. Residents and families reported there are enough toilets and they are easy to access. Engaged and vacant signs are on the doors.

adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		Appropriately secured and approved handrails are provided and other equipment is available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Bedrooms are a mix of different sizes. There is adequate space provided for residents and staff to move safely around in all the bedrooms. Rooms are personalised with furnishings, photos and other personal adornments. Adequate room is available in the facility to store mobility aids such as mobility scooters, wheelchairs and walkers.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Areas are provided for residents to frequent for activities, dining, relaxing and for privacy. Residents, families and staff confirmed and observation evidenced these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The facility includes places where young people with disabilities can find privacy within the communal spaces. There is consideration of compatibility with residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is washed on site. Residents and families reported the laundry is managed well and residents' clothes are returned in a timely manner. Dedicated cleaners and laundry staff have received appropriate education. The cleaner and laundry staff demonstrated knowledge of processes. The facility is not cleaned to an acceptable standard and residents, families and staff confirmed this. (See 1.4.2.4). Chemicals are stored securely with a closed system used. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during	FA	The current fire evacuation plan was approved by the New Zealand Fire Service on 21 July 2001. An evacuation policy on emergency and security situations covers the service groups at the facility including the special needs of young people with disabilities in an emergency. Flip charts were sighted around the facility including all emergency procedures. A fire drill takes place six-monthly, the last on the 13 December 2019. The orientation programme includes fire and security education.

emergency and security situations.		Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted and all equipment had been checked within required timeframes. There is always at least one staff member on duty with a current first aid certificate. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs. Back up battery powered lighting is available should there be a power outage. There are call bells to alert staff. Contractors must sign in and out of the facility. The external doors are locked in the evenings. There are security cameras externally and internally in the communal areas. Residents and families reported they were made aware of the security system as part of the admission process.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Heating is provided by heat pumps in the communal areas and individual wall heaters in the bedrooms. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. There are covered and uncovered external areas for smokers.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Lester Heights Hospital has implemented an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from external specialists. The infection control programme is reviewed annually and was incorporated in the monthly meetings and a review of the education programme is conducted. The CM is the designated infection prevention and control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results are reported monthly to the quality assurance manager and to the monthly staff and management meetings. The infection control manual provides guidance for staff on how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents. There is information that covers aspects of infection control for family/whanau and if they are unwell; it is recommended that they do not visit the service. During higher risk times of community

		infections and winter months, notices are placed at the door to remind people not to visit if they are unwell. There is sanitising hand gel at the entrance and throughout the service. Hand washing facilities and sanitiser dispensers are readily available around the facility. No infection outbreak has been reported since the previous audit. Information on the management of the novel coronavirus was readily available for staff and visitors.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection prevention and control coordinator (ICC) has appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control. Additional support and information are accessed from the infection control team at the DHB and the GP as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection.
Standard 3.3: Policies and procedures 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.	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by the organisation with advice from external specialists. Policies were last reviewed in August 2019 and included appropriate referencing. 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. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education on infection prevention and control is conducted by the ICC and other specialist external consultants. Hand hygiene training and competency checks were completed for staff on 22 January 2020. The education information pack is detailed and meets best practice and guidelines. The infection control coordinator attended infection prevention and control training conducted by an external consultant to keep their knowledge current. A record of attendance was maintained and was sighted. External contact resources included the GP, laboratories and local district health

		boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they were informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service demonstrated the use of restraint is actively minimised. There were two residents using restraints and seven residents using an enabler during the audit. The restraint coordinator is the lead RN and demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register was current and updated. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two. Restraint is an agenda item at the staff meetings. Meeting minutes and staff confirmed this.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The use of restraint is approved prior to commencing the restraint, this includes the resident's GP. Three-monthly reviews of restraints are completed. A signed job description for the restraint coordinator was evident in the restraint coordinator's file. Responsibilities of the restraint coordinator and approval are clearly outlined. Restraint use is discussed in the RN and staff meetings. Staff confirmed their knowledge of the restraint processes.
Standard 2.2.2: Assessment Services shall ensure rigorous	FA	Files of residents using restraint and enablers were reviewed. Restraint assessment/consent forms were completed prior to commencing restraint. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. Long term care plans clearly documented

assessment of consumers is undertaken, where indicated, in relation to use of restraint.		any risk and desired outcomes. Staff demonstrated knowledge of maintaining culturally safe practice when completing assessments for restraint use.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Restraint minimisation policies and procedures are accessible for all staff to read. Safe use of restraint is actively promoted. There was a current and updated restraint/enabler register. Care plans include any risk factors and ensures the resident's safety while using restraint. Staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. There were no restraint-related injuries reported. Monitoring forms are in place for all residents who are using restraint and enablers and these were completed as required.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	PA Low	Residents using restraints and enablers are evaluated at least three-monthly and the resident's care plan six monthly. The evaluation consists of "No Change" and does not meet requirements. Staff confirmed feedback was obtained by the restraint coordinator when evaluating the restraint in use.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The quality review of restraint is monitored through the internal audit programme. Identified issues are discussed at the staff meetings as well as additional education that is required to support staff. This includes education relating to restraint and challenging behaviour. Staff demonstrated sound knowledge relating to managing challenging behaviours. Equipment such as sensor mats and low-low beds are used to minimise the use of restraint.

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)
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	A business plan for the organisation was not available for review during the audit. The O/M did provide a one-page document that consisted of eight goals. The goals are reviewed quarterly. The service philosophy was displayed at the front entrance. It includes younger people with a physical disability.	A business plan was not available for review.	Develop and implement a business plan that includes a purpose, scope, objectives and direction of the organisation and reflects a person/family centred approach. 30 days
Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.	PA Low	The organisation has a quality and risk management system that is robust and staff demonstrated a sound understanding. Benchmarking with all other local facilities is undertaken quarterly	Separate meetings are not held for the YPD	Provide documented evidence that the YPD residents have regular

		by the local DHB and shared with staff. Internal audits are completed as per the audit programme and corrective actions developed and implemented. Meetings are held on a regular basic including full staff meetings that include quality, health and safety, restraint, infection prevention and control and complaints. Quality data including graphs is presented and discussion is held around corrective actions. Registered nurse meetings are held prior to the full staff meetings and include discussion around specific residents. Review of minutes confirmed this. Resident meetings are held three monthly and include topics of interest. The Younger residents with a physical disability do not have separate meetings held and they reported there was no recognition or discussion concerning their different needs. Review of the meeting minutes evidenced general discussions only. The YPDs stated they would be keen to have separate meetings to the general residents' meetings.	residents.	meetings held to discuss their particular needs. 30 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The education programme for 2018 and 2019 was reviewed. In-service education is provided for staff prior to each staff meeting and shift handover including specific topics relating to resident's health status. Registered nurses and HCAs attend ongoing education provided by the local DHB. Individual staff records of education and attendance records are held and were reviewed. Competencies were current including but not limited to	Staff have not been provided with specific training relevant to younger people with physical disabilities	Provide evidence that staff have been provided with in-service education relating to younger people with physical disabilities.

		medicines and restraint. Staff have not been provided with specific training relevant to younger people with physical disabilities since 2018. The O/M reported difficulty in finding an appropriate speaker and although one was arranged for 2019, the person did not keep the appointment. A New Zealand Qualification Authority education programme is available for staff to complete and they are encouraged to do so. All HCAs have level 2, some have level three with four currently completing level 4.	since 2018.	60 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	There was an approved food plan for the service. Meals are prepared on site and served in the allocated dining rooms. The menu was last reviewed 31 July 2017 by a registered dietitian to confirm it was appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer menu in place. Meeting minutes and the kitchen diary sighted confirmed that changes were made on the menu in use following consultation with residents.	The menu has not been reviewed by a registered dietitian in a timely manner following changes made to it to confirm it was appropriate to the nutritional needs of the residents.	Ensure the menu is reviewed by a registered dietitian to confirm it meets the nutritional needs of the residents. 180 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop	PA Low	The activities coordinator is enrolled in a New Zealand certificate in Kaupapa Maori Public health level 4. The activities	Five out of eight activity plans were	Provide evidence that activity plans are

and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.		coordinator reported there is a volunteer who visits every fortnight to talk to residents. An activity planner was sighted that has a variety of activities either individually or in group sessions. There were activities planned for YPD residents. Attendance was monitored electronically, and an evaluation printed off every month. Weekly activities were posted on the notice boards. Residents' files had a documented activity plan that reflected the residents' preferred activities of choice. The activities vary and included scrabble, bingo, bowls, snakes and ladders, Netflix movies, haven falls singing group, exercises/walking and church services. A school holiday activities programme for a YPD resident who attends school was in place. The service participates in yearly 'Olympics' with other providers in the region. The activities programme is reviewed annually by the activities coordinator and assistant manager in consultation with residents and family/whanau through satisfaction surveys. Review/evaluation of individual activities plans were completed six-monthly, but not evaluated following interRAI assessments, resulting in some interRAI triggered items not addressed in the activities care plans reviewed. Residents were not provided with adequate opportunities to have outings and this was reported as a concern in interviews conducted with residents and family.	not evaluated following interRAI assessments resulting in some triggered items not being addressed in the activities care plans. No regular outings for all residents to access other community support services as preferred by residents.	evaluated/reviewed following interRAI assessments. Ensure there are opportunities for residents to access activities in the community. 90 days

Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Moderate	The internal environment requires maintenance. Surfaces throughout the facility have been damaged and were in need of painting and protection. Passageways, corners and doors have been damaged by wheelchairs and hoists. The door to one of the sluices had a metal protector in place which was damaged and unsafe and the sluice had holes in the wall. The metal protector was replaced and the holes filled while the auditors were on site. The facility externally is maintained to an adequate standard. Cleaning of the facility is not to an acceptable standard. The facility looked unclean with dirt visible throughout, especially in the corners of rooms. Families, staff and residents reported they find the facility dirty and one family member reported they put an item under their relative's bed to see if it was removed; however, six weeks later it was still in the same place. Toilets needed cleaning and the cleanliness of the stainless-steel tub and sluice in one of the sluice rooms was unacceptable. This was cleaned before the second day of the audit.	Maintenance and cleaning in the facility is not maintained to an adequate standard.	Provide evidence that: (i) walls, doors and corners that have been damaged are painted and protected and the entire facility is maintained to an adequate standard; (II) the cleanliness of the facility is maintained to an adequate standard. 90 days
Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	PA Low	There are external areas available, mainly at the front of the facility that are maintained to an adequate standard. The external raised gardens around the back are full of weeds and look unkept. The	The gardens around the back of the facility look unkept and	Maintain the raised gardens, provide shade for residents and families and review the items

		area around the side of the building has empty containers lying about. The O/M reported the ice-cream containers are for water for the dogs and the empty tins are for the smokers to use. There is no shade for residents who venture outside. The O/M reported the shade cloth had ripped off the uprights and has not been replaced. The external areas do not encourage residents to enjoy the outside. Residents confirmed this.	require attention. There was no shade available for residents and families. The containers used to water the dogs and for smokers do not enhance the external area.	used to provide water for the dogs and for smokers use. 60 days
Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed;	PA Low	The template for the assessment/consent for restraint use has a small section at the bottom for the three-monthly evaluation. The evaluation does not include items (a) to (J) of this criterion and consists of “No Change” only.	The evaluation of restraint use does not include the requirements of this criterion.	Develop and implement an evaluation form that includes the requirements of the criterion. 30 days

(k) Any suggested changes or additions required to the restraint education for service providers.				

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.