

Tairua Residential Care Limited - Tairua Residential Care

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:	Tairua Residential Care Limited
Premises audited:	Tairua Residential Care
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 February 2021 End date: 11 February 2021
Proposed changes to current services (if any):	Nil
Total beds occupied across all premises included in the audit on the first day of the audit:	39

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

Tairua Residential Care can provide care for up to 44 residents requiring either rest home or hospital (medical or geriatric) level of care. On the day of the audit, there were 39 residents in total.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner.

The nurse manager (owner) is responsible for operational management of the facility and for clinical oversight and leadership.

Improvements are required to the following: documentation to confirm that family have been informed of incidents; signing of consent forms and completion of advance directives; the complaints system; policy review; the quality and risk management programme; admission agreements; timeframes, interventions; medication management; food services; storage of chemicals; and restraint programme.

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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Residents receive services in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The systems protect their privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

The nurse manager has an open-door policy. There is a documented complaints policy and procedure.

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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There is an annual business, quality and risk management plan in place which defines the scope, direction and objectives of the service and the monitoring and reporting processes. The framework around a quality and risk management system is documented.

The human resource management system is documented. There is an orientation programme in place. A training schedule is implemented.

There is a documented rationale for determining staff levels and staff mix in order to provide safe service delivery in the rest home and hospital. An appropriate number of skilled and experienced staff are allocated each shift with a full complement of registered nurses now in place.

Resident information is stored securely.

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.
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Care plans are developed, maintained and reviewed by the registered nurses. A registered nurse is expected to assess and review residents' needs, outcomes, and goals with the resident and/or family/whānau having input. Care plans reviewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses (RNs), and senior caregivers are responsible for administration of medicines and complete annual education.

A range of individual and group activities is available and coordinated by the activity coordinators. The activity coordinators implement the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are considered.

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 low risk.
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The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Resident bedrooms are personalised.

Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services.

Documented systems and supplies are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There are two residents at the service using enablers and three residents using restraint at time of audit. Processes to assess for the need for restraint, consent by family and the general practitioner, care planning are documented in the policy.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Responsibility for infection control is the nurse manager. Staff complete annual training on infection control. There is a suite of infection control policies and guidelines to support practice. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	38	0	3	9	0	0
Criteria	0	82	0	9	10	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Policies and procedures are in place to ensure consumer rights are respected by staff. Staff receive education during orientation and ongoing training on consumer rights is included in the staff annual training schedule.</p> <p>The nurse manager (owner) and 14 staff interviewed (including five caregivers; two registered nurses; two activities coordinators; health and safety representative; the cook; maintenance; laundry staff; infection control coordinator) were all able to articulate knowledge of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. Staff interviewed confirmed they receive ongoing education on the Code, and they are able to articulate how they apply this knowledge to everyday practice.</p> <p>Visual observations during the audit and the review of clinical records and other documentation indicated that staff are respectful of residents and incorporate the principals of the Code into their practice. The service provides information on the Code to families and residents on admission.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where</p>	<p>PA Moderate</p>	<p>There is an informed consent policy in place (link 1.2.3.3). Documentation of consent is expected to be included in each resident's record. Staff use verbal consents as part of daily service provision. Staff demonstrated an understanding of informed consent processes. Residents and relatives confirmed that</p>

<p>appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>consent issues are discussed with the relatives and residents on admission. Not all resident files reviewed included documented written consent including advanced directives.</p> <p>Caregivers interviewed stated that residents had choice and gave verbal consent when asked. Caregivers were informed re who was for resuscitation if the form had been completed in the resident record.</p> <p>There is a policy that reflects evidence and best practice around advanced directives. Residents deemed competent by the nurse practitioner are expected to be asked to complete an advance directive if they choose.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There are policies in place regarding advocacy and/or support services.</p> <p>Advocates can be accessed through the Nationwide Health and Disability Advocacy Service if required. The Nationwide Health and Disability Advocacy Service brochure is offered to the resident and their family/whānau on admission. These brochures are also displayed in the entrance foyer. Education on advocacy is provided to staff during orientation and in the ongoing in-service programme.</p> <p>Residents and relatives interviewed confirmed they are aware that advocacy services are available should they be needed.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents have open access to visitors of their choice. Resident safety and well-being are not compromised by visitors to the service. Access to community support/interest groups is facilitated for residents as appropriate. The activities staff are available to take residents on community visits and staff are available to take people to appointments if family are not able to provide transport. There is a volunteer who can drive residents into the community as required.</p> <p>Residents interviewed confirmed they can have access to visitors of their choice at any time and are supported to access services within the community. Family were seen visiting residents on the days of audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and</p>	<p>PA Moderate</p>	<p>The complaints management policy and procedure are documented and follows the Code (link 1.2.3.3). The complaints policy and procedure are explained by the staff as part of the admission process.</p> <p>The complaints process is not well linked to the quality programme (link 1.2.3.5).</p> <p>There are complaint forms available at the main entrance to the building. The nurse manager manages resident complaints. An up-to-date resident complaints register is expected to be maintained as part of the</p>

<p>upheld.</p>		<p>Towards Improving Services (TIS) forms, with these including a monthly register of any complaints.</p> <p>Two complaints were received from external authorities. One relating to discrimination has been closed with the no further actions required and the family confirmed as being satisfied with the outcome. One relating to care is open with the nurse manager responding to requests from the external authority for documentation. Staff, residents and families interviewed have a good understanding of the complaints process.</p> <p>Family and residents interviewed on the whole stated that they have not had to complain formally but stated that any suggestions are treated seriously, with improvements when appropriate.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Information on the Code and the Nationwide Health and Disability Advocacy Service is displayed in the facility and included in the admission information pack. The Code and other rights and information in the information pack are discussed with residents and relatives on admission.</p> <p>Eight residents (seven in the rest home and one hospital) and three rest home relatives interviewed confirmed that the Code, the advocacy service, and residents' rights are explained on admission. Residents and family interviewed stated that they receive services as per the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>There are a range of policies and procedures in place to ensure residents are treated with respect. Staff endeavour to maximise residents' independence. There is respect for residents' spiritual, cultural and other personal needs.</p> <p>The service has a philosophy that promotes dignity and respect and quality of life. Residents' support needs are assessed using a holistic approach. The assessment process includes gaining details regarding people's beliefs and values. Residents and family confirmed that they are included in the care planning process and are addressed by their preferred name as confirmed by residents interviewed.</p> <p>Caregivers stated that they support the residents' independence by encouraging them to be as active as possible. Caregivers could describe how they encourage each resident to remain involved in and with the community. Residents interviewed could describe how they were supported to visit friends and were observed to be in the township.</p> <p>A policy is available for staff to assist residents in managing personal practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner. This includes strategies to manage any behaviours of concern. Staff were able to describe support for residents around sexuality and intimacy.</p> <p>The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility that can be used for private meetings.</p>

		<p>Caregivers reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit and confirmed by residents interviewed.</p> <p>Residents and relatives interviewed stated that staff have regard for the dignity, privacy, and independence of residents.</p> <p>There is a policy around abuse and neglect. Staff could describe the process for managing any issues related to abuse and neglect. Staff, residents and family and the general practitioner interviewed stated that there is no evidence of abuse or neglect. There were no incidents documented in 2020 or 2021 related to abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff in care provision for Māori residents. The documentation is referenced to the Treaty of Waitangi and includes guidelines on partnership, protection, and participation.</p> <p>Staff interviewed confirmed an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training at least annually.</p> <p>There is one resident who identifies as Māori and the staff and nurse manager stated that any cultural needs are met through family.</p> <p>Access to Māori support and advocacy services are available if required through the district health board. Systems are in place to allow for review processes including input from family/whānau as appropriate, for residents who identify as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan.</p> <p>Staff interviewed confirmed their understanding of cultural safety in relation to care.</p> <p>Residents and family members interviewed confirmed that values and beliefs are respected by staff. Family stated that this is a strength of the service.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions.</p> <p>Staff interviewed demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives interviewed reported that staff maintain appropriate professional boundaries. One complaint related to potential discrimination has been investigated by external authorities however this has been closed with no actions required by the service. A second complaint from the Health and Disability advocate related to care of a resident is currently being investigated by external authorities with this still open. The service is responding to the request by the external provider for further information.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Residents stated that they receive a high quality of service and all stated that they enjoy living at the facility. Family also confirmed residents' acknowledgement of the quality of service. Residents and family described a culture of caring and support.</p> <p>There are policies and procedures in place to guide service delivery (link 1.2.3.3). Management and staff have access to and demonstrate knowledge of approved service standards. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice.</p> <p>The education programme includes training requirements for staff with external experts facilitating some training sessions. Staff interviewed confirmed that there is a supportive environment.</p> <p>The nurse manager maintains strong links with the community and has an extensive knowledge of family/whānau links. This includes knowledge and understanding of residents' needs relative to their community.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>PA Low</p>	<p>The service provider has policies covering communication, access to interpreters and the nurse manager maintains an open-door policy (link 1.2.3.3). Information is provided in a manner that the resident can understand. Relatives and residents stated that they can discuss issues at any time with staff. Resident meetings are conducted monthly, and residents interviewed confirmed that these are useful forums to raise any issues.</p> <p>Residents and relatives interviewed confirmed that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirmed that they are advised if there is a change in their family member's health status. The incident and accident forms include an area to document if the relatives have been contacted following an incident or accident. Not all incidents reviewed reflect family were informed.</p>

		<p>Interpreting services are available through the district health board. There are no residents requiring the use of interpreting services.</p> <p>Family and residents stated that there was a lot of information made available during the Covid-19 pandemic. Both residents and family stated that there was frequent communication and family stated that they were kept updated around their family member's progress.</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>	FA	<p>Tairua Residential Care has been in operation since April 2011 and is privately owned. The service provides for residents requiring rest home or hospital level of care with 29 residents requiring rest home level of care (32 beds identified as being available for residents requiring rest home level of care), and 10 residents requiring hospital level care (12 available beds). One resident is under an LTS-CHC contract (long-term support-chronic health care) and one hospital resident is under a post-acute convalescent care contract. All other residents are under an Age-Related Care contract.</p> <p>The philosophy, mission statement and values are documented and known to staff, residents and family members. The mission statement is 'to assist residents, respectfully and with dignity; to safely enjoy life, love and laughter in their own way, time and space'.</p> <p>Organisational performance and clinical oversight and management is monitored and overseen by the nurse manager (owner). The nurse manager has over 40 years nursing experience and 20 years' experience in rest home and hospital management. The nurse manager has completed at least eight hours of education in the last year to maintain their practising certificate.</p> <p>The business plan for 2020 has been reviewed prior to the development of a new plan. The business plan for 2021 is documented and this includes business goals and objectives, accountabilities, timeframes, and measures to report against. An organisational risk management plan is documented with this reviewed annually and as changes occur. A marketing plan is documented and reviewed annually.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe</p>	FA	<p>The nurse manager is a registered nurse and provides a leadership role. A senior registered nurse is designated as the second in charge and is able to provide cover for the nurse manager in the event of their absence. The nurse manager also stated that they are always in phone contact even if absent.</p>

services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>The quality and risk management programme identifies objectives for the service. A quality plan is documented with goals, accountabilities, timeframes and measures to report against. There is an annual review of the quality plan with this completed in December 2020. Goals are also discussed on a monthly basis at the staff meetings.</p> <p>Activities within the quality and risk management programme include health and safety, adverse event reporting, infection prevention and restraint minimisation. There are policies in place; however, these require review to reflect changes in legislation and to meet policy expectations re review. A document control system is implemented.</p> <p>Quality related data and outcomes are collated. There are monthly staff meetings held to discuss issues with documentation in meeting minutes; however, these do not always evidence clinical review and discussion. Not all aspects of the quality programme are linked to the staff meetings. Staff interviewed described input into the quality and risk management programme. An internal audit schedule is not fully implemented as per documented timeframes. Corrective action plans documented do not show evidence of resolution of issues.</p> <p>There are quarterly resident meetings and family are able to attend if they wish. There is evidence of discussion and feedback on any areas for improvement identified. Corrective action plans are documented with evidence of resolution of issues.</p> <p>A satisfaction survey held in 2018 showed that residents were satisfied with care.</p> <p>Health and safety requirements are being met, including hazard identification. A substance register identifies hazards associated with chemicals and there are material safety data sheets. Managers, staff, residents, and family could describe input into the health and safety programme through relevant meetings and through discussions with the nurse manager. A health and safety officer is appointed to the service to provide oversight of implementation of the policy.</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</p>	<p>PA Moderate</p>	<p>There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are being reported. Immediate responses to the incident are documented.</p> <p>The incident forms completed show some evidence of investigations and remedial actions being implemented as required.</p> <p>Incidents that are unwitnessed or that include an injury to the head do not show that neurological recordings are taken for a sustained period (refer 1.3.6.1). The review did not confirm that documented</p>

<p>family/whānau of choice in an open manner.</p>		<p>incidents and accidents are closed in a timely manner.</p> <p>The nurse manager understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. There have been two Section 31 forms reported to external authorities since the last audit. These were around a complaint and for an unexpected death that as referred to the coroner. The nurse manager completed a section 31 on the day of audit to confirm the resignation of the clinical nurse manager.</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>FA</p>	<p>There is an established system in place for human resource management.</p> <p>All staff records reviewed included an employment agreement, position description and completed orientations on file.</p> <p>Professional qualifications are validated with a current annual practicing certificate on file for registered nurses; the medical officer; physiotherapist and pharmacist. All staff receive an orientation and participate in ongoing education when this is offered. Performance appraisals are completed for all staff who have been employed for 12 months or more.</p> <p>There is a registered nurse in charge on each shift. Files of registered nurses reviewed hold current first aid certificates with 12 staff documented as having completed first aid training (certificates sighted). There are three registered nurses trained in interRAI.</p> <p>There is an annual training plan that is implemented and attended routinely by staff. Attendance records are kept for each session with documentation of what is covered in each session. Staff stated that they find the training relevant to their roles. Some sessions are facilitated by a registered nurse and at times, there are sessions facilitated by specialists from the district health board or other providers such as Hospice.</p> <p>Medicines are given by registered nurses and caregivers who have been assessed as competent. Staff participate in meetings and confirmed that they are kept up to date on changes occurring within the service or matters of concern through handover and open dialogue with the nurse manager.</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</p>	<p>FA</p>	<p>The process for determining provider levels and skill mix is defined in policy and considers the layout of the facility and levels of care provided. The nurse manager develops staff rosters. Rosters and staff interviewed and observation on the days of audit confirmed there were sufficient numbers of staff in each area to meet minimum requirements as specified in the Aged Residential Care Agreement.</p> <p>Registered nurses are on duty each shift and are supported by caregivers including staff who have been</p>

<p>providers.</p>		<p>working in the service for between one and over ten years. There is a low rate of staff turnover.</p> <p>The nurse manager is on site Monday to Friday. Staff are rostered onto one of three shifts and allocated to hospital or rest home wings. There are five caregivers on duty in the morning; three in the afternoon as well as a short-shift and one overnight. Acuity and numbers of residents is considered when rostering staff. Rosters reviewed confirmed that there is always a replacement staff member when a rostered staff is on leave.</p> <p>The nurse manager lives close by and is on call at all times. Staff stated that the nurse manager (or registered nurse if relieving) responds immediately in the event of an emergency.</p> <p>There is a staff member on duty on each shift, with a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Paper-based resident records are maintained for each resident. All records are maintained confidentially. The resident records are stored in a secure manner. The files record information for ongoing care and support being provided. Records are integrated.</p> <p>A record of past and present residents is maintained. InterRAI assessments are completed by the registered nurses and inform the development of the resident's plan of care. Progress records are clearly documented by the care staff in the paper-based record. The date, time, signatures and designation of those entering into the records is legible.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>PA Low</p>	<p>Residents' entry into the service is facilitated in a timely and respectful manner. Admission information packs on the services for rest home and hospital level care, are provided for families and residents prior to admission or on entry to the service. Four of seven admission agreements reviewed were not signed by the service or by family or resident. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</p>	<p>FA</p>	<p>The service has policies describing guidelines for death, discharge, transfer, documentation, and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. The DHB yellow envelope scheme is used to ensure all appropriate documentation is sent with the resident in</p>

transfer from services.		cases of transfer to public hospital.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management system includes a medication policy and procedure that follows recognised standards and guidelines for safe medicine management. The service uses a paper-based medication system. All residents have individual medication orders with photo identification and allergy status documented. All medicines are stored securely when not in use. The service uses blister packs for regular medication and 'as required' medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the medication room. Short-life medications (i.e., eye drops and ointments) are dated once opened. Registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis, however caregivers who check and double sign for medication have not. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training (certificates sighted). Administration sheets sampled were all appropriately signed. 'As required' medications had indications for use charted.</p> <p>Thirteen of fourteen medication charts reviewed could not evidence that the GP had reviewed the resident's medication three-monthly. A registered nurse was observed administering medications and seen to crush medications for four residents who did not have this indicated by the prescriber on their medication charts.</p> <p>There were no residents self-medicating on the day of audit. Standing orders are not used and there are no vaccines stored on site. Medication fridges are maintained within the acceptable temperature range.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>All meals at the service are prepared and cooked on site. The kitchen was observed to be clean and well run. Temperatures were monitored and recorded for fridges and freezers and one resident food fridge had temperature readings higher than the accepted range daily for over a month with no documented corrective actions. The cook interviewed at time of audit advised that temperatures are not consistently taken for cooked meals and that these are not recorded.</p> <p>The food control plan has not been verified. The menu had been referred to a dietitian for review and correspondence regarding this was seen at time of audit.</p> <p>Staff were observed delivering meals and assisting residents with their lunchtime meals as required. Diets were modified as required. Resident dietary profiles and likes and dislikes were known to food services staff and were seen to be displayed in the kitchen on day of audit.</p> <p>Resident meetings and surveys allowed for the opportunity for resident feedback on the meals and food services generally. The cook seeks verbal feedback directly from residents in the dining room during meal</p>

		service. Interviews with residents and family members indicated satisfaction with the food service. Alternatives are offered for dislikes.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools. Initial interRAI assessments had not been completed for all long-term residents' files reviewed (link to 1.3.3.3). Files sampled indicated that not all appropriate personal needs information is gathered during admission (link 1.3.3.3). Four of seven care plans reviewed did not reflect the care requirements of the consumers as assessments of resident need had not been completed prior to the care plan being produced (link 1.3.5.2).
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	All seven resident files reviewed have a documented care plan in place. Care staff interviewed were very knowledgeable regarding care and support needs for the residents. Resident care plans reviewed did not include all care and support as documented in interRAI assessments, progress notes or other assessments. Handovers evidenced that in-depth resident information is discussed to ensure safe care.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The registered nurses complete care plans for residents. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status (link 1.3.5.2). Staff stated that they notify family members about any changes in their relative's health status, and this was confirmed by family members interviewed who stated they are notified of any changes to their relative's health (link 1.1.9.1).</p> <p>Wound assessment, appropriate wound management and ongoing evaluations were in place for all wounds. Wound monitoring occurred as planned. There were twelve ongoing wounds for seven residents including two chronic wounds, seven skin tears, one graze, one haematoma and one grade 2 pressure</p>

		<p>injury (facility acquired). There was evidence of wound nurse specialist involvement in chronic wounds management.</p> <p>Continence products are available and care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.</p> <p>Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring. While monitoring is completed; gaps were noted around neurological observations (link 1.2.4.3) and restraint (link 2.4.)</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service currently employs four activities coordinators. The programme is planned monthly, and activities planned on the day were displayed on noticeboards around the facility. On the days of audit residents were observed participating in activities. The activities coordinator seeks verbal feedback on activities from residents and families to evaluate the effectiveness of the activity programme, enabling further adaptation if required. The majority of residents interviewed were positive about the activity programme.</p> <p>Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. There are weekly outings to places chosen by the residents and there are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and other festive days are celebrated. There are visiting community groups such as church groups and the local school. The activity team provide a range of activities which include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, petanque and bingo.</p> <p>Those residents who prefer to not to participate in communal activities receive one-on-one visits and individualised activities according to their preferences.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Two of the seven resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. Five of the seven resident care plans reviewed were recent admissions and did not require evaluation at the time of audit. Activities plans for the two residents had also been evaluated six-monthly at the same time as the review of the care plan. The registered nurse spoke of three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so. These reviews were evident in the resident's medical notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability</p>	FA	<p>Tairua Residential Care facilitates access to other medical and non-medical services. Referral to other health and disability services is evident in the sample group of resident files. The RNs initiate referrals to</p>

<p>Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>nurse specialists, and allied health services. Other specialist referrals are made by the GP. Referrals and options for care were discussed with the family, as evidenced in medical notes. Referral documentation is maintained on resident files. The registered nurses interviewed gave examples of where a resident's condition had changed, and the resident had been reassessed for a higher or different level of care. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required. There are documented policies and procedures in relation to exit, transfer or transition of residents.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>PA Low</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Not all chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness, which expires on 22 September 2021.</p> <p>The service employs a maintenance person for three days a week plus on call as required. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes six monthly building compliance checks, (e.g., hot water temperature, call bells, resident equipment and safety checks). Medical equipment has an annual calibration which is next due in January 2022. Electrical appliances have been tested and tagged and are next due to be tested in September 2021. Essential contractors are available 24-hours.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and courtyards on the ground floor. There is a designated outdoor smoking area. Seating and shade are provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	<p>FA</p>	<p>The rest home resident rooms are single rooms with hand basin and toilet ensuite. There are communal showers available. The hospital wing has communal showers and toilets available for resident's use. There are communal toilets with privacy locks located near the communal areas. Visitor toilet facilities are</p>

<p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>available. Fixtures, fittings, floorings and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Residents interviewed reported their privacy is maintained at all times. The communal toilets and showers are well signed and identifiable and include vacant/in-use signs.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility equipment. Residents are encouraged to personalise their bedrooms with personal belongings as viewed on the day of audit. Staff interviewed reported that they have more than adequate space to provide care to residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are large and small communal areas. Activities occur in all lounges and dining areas which are large enough to cater for the activities on offer, are accessible and can accommodate the equipment required for the residents. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The lounge and dining areas are spacious, inviting and appropriate for the needs of the residents. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance during the audit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry persons and cleaning staff on duty seven days a week. The laundry and cleaning staff have completed chemical safety training and laundry processes. There is a cleaning manual available. Laundry is transported in covered trolleys to the laundry. The laundry has a designated dirty to clean flow. There is appropriate personal protective-wear readily available. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard (link 1.4.1.1). All chemicals on the cleaner's trolley were labelled. Cleaning and laundry services are monitored through the internal auditing system. Sluice rooms were kept locked when not in use. Residents and family interviewed reported satisfaction with the cleaning and laundry service.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. There are emergency flip charts throughout the facility for all emergency disasters. Civil defence supplies are readily available within the facility and include water, food and supplies (torches, radio and batteries), emergency power and barbecue. The service has alternative gas facilities for cooking in the event of a power failure. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. Smoke alarms, a sprinkler system, evacuation notices and exit signs are in place.</p> <p>There is sufficient water stored to ensure for three litres per day for seven days per resident stored in an external tank. Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Residents have call bells within reach (sighted) and this was confirmed during resident and relative interviews.</p> <p>The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. Access by public is limited to the main entrance. Covid-19 sign-in is mandatory for visitors and staff. The building is secure after-hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Residents are provided with adequate natural light and safe ventilation. All bedrooms and communal areas have at least one external window. The environment is maintained at a safe and comfortable temperature with central heating, which can be adjusted to meet individual requirements, each room having individual thermostats and temperature controls. The residents and family interviewed confirmed temperatures were comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and</p>	<p>FA</p>	<p>The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system with infection control reports presented at the monthly staff meeting. A registered nurse (nurse manager) is the designated infection control coordinator. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>

scope of the service.		
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. Information is shared as part of staff meetings. External resources and support are available through the DHB, external specialists, microbiologist, GP and wound nurse when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The policies and procedures are appropriate for the size and complexity of the service and have been reviewed by the IC coordinator and team. Infection control procedures developed in respect of care, the kitchen, laundry and housekeeping incorporate the principles of infection control. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.</p> <p>A facility Covid strategy and pandemic plan was available to staff on site with education and associated resources relating to hand hygiene, PPE and donning/doffing procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff is included in the annual training plan and staff have completed infection control education in the last 12 months. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is reported at the monthly staff meetings. Data and</p>

<p>carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>graphs of infection events are available to staff. Trends are identified and analysed, and preventative measures put in place.</p> <p>Systems in place are appropriate to the size and complexity of the facility, there have been no outbreaks in the last 12 months.</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>There is a policy around use of enablers and restraint. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There are two residents at the service using enablers and three residents using restraint at time of audit (bedrails and one having access to a lap belt if required). There is evidence that staff use strategies to minimise restraint and restraint practices are the last resort.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews. One resident record was reviewed for a resident using an enabler. The review confirms that an assessment had been completed and the care plan referred to the use of the enabler (bedrail).</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	<p>FA</p>	<p>Lines of responsibility for the restraint process including approval of the use of restraint is documented in the policy. The service has a process for determining approval of the types of restraint used and this is implemented when required. Each record reviewed (two where a resident used a bedrail identified as restraint) included a consent form for the use of the restraint that was signed by the general practitioner, the restraint coordinator (nurse manager) and the family member.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The registered nurse is expected to complete an interRAI assessment that includes assessment of restraint use prior to commencement of any restraint (link 1.3.3.3). The registered nurse completes an assessment around restraint as a specialised assessment and this includes all factors listed in 2.2.2.1.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Strategies are implemented prior to use of restraint to prevent the resident from incurring injury. The strategies are documented in the restraint care plan and referenced also in the long-term care plan. Staff and management interviews confirmed knowledge of the strategies documented with these individualised to the resident.</p> <p>Restraint is described as being the last resort. The two files reviewed confirmed that the environment is considered prior to using restraint; that the reasons and desired outcomes for use of the restraint are documented and any alternative interventions of outcomes are considered.</p> <p>A register of the restraint is updated when any new restraint is used or following a reassessment or care plan review.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>PA Moderate</p>	<p>Each episode of restraint is evaluated for its effectiveness and need of continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters.</p> <p>Frequency of monitoring of restraint is expected to be documented in the care plan. This did not occur in two of two files reviewed where restraint was used. One incident form reviewed along with subsequent documentation in the resident record showed a potentially serious event that was managed by staff on duty who were with the resident when the even occurred. There was no documentation of frequency of monitoring of the restraint documented in the care plan. Staff tick in the progress notes to confirm that restraint has been used during the shift. The time the restraint was put on and taken off and frequency of monitoring is not documented.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The individual resident's restraint reviews and restraint register updates are conducted. Staff interviews confirmed their awareness of the residents who require restraint and the residents who requested the use of enablers. The staff meeting minutes record discussions on restraint. Residents' progress notes evidenced restraint is monitored and evaluated at each shift, when in use. The observed handover confirms that any use of restraint is discussed with outcomes of use confirmed.</p> <p>A review of an incident form where restraint was used and a review of one other resident record identified poor outcomes from the use of restraint. The nurse manager was informed immediately, and actions were taken to prevent the use of the restraint from then on.</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)
Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.	PA Low	Seven resident records were reviewed. Three included a signed consent form. Some resident records did not include an informed consent form. Residents without a consent form had been admitted between June and December 2020.	Four of seven resident records reviewed did not have informed consent forms completed.	Ensure that residents or family complete a consent form on entry to the service. 90 days
Criterion 1.1.10.7 Advance directives that are made available to service providers are	PA Low	One of seven records included an advance directive. This was completed by the GP (Medically initiated DNR) as the resident was not able to give an advance directive.	Six of seven resident records did not include an advance directive.	Ensure that residents are asked if they wish to sign an advance directive. 90 days

acted on where valid.				
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	<p>PA Moderate</p>	<p>There is a complaints policy that includes timeframes as per The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Two complaints have been received by external authorities. The nurse manager has completed documentation for the external provider in one instance with this closed with no further actions required. The second complaint from an external provider is open and the nurse manager is completing documentation requested by the external authority.</p> <p>The complainants are expected as per policy, to be provided with written confirmation of the complaint or written documentation of progress of the investigations.</p>	<p>The complainants have not been provided with written confirmation of the complaint or written documentation of progress of the investigations as per the complaints policy.</p>	<p>Provide written confirmation that the complaint has been received and progress as per the investigation to the complainants as per the complaints policy.</p> <p>60 days</p>
<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 Low</p>	<p>A register is available to document complaints. This is not currently in use. Documentation related to a complaint is kept in an individual resident folder.</p>	<p>A complaints register is not maintained.</p>	<p>Maintain an up-to-date complaint register.</p> <p>90 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank</p>	<p>PA Low</p>	<p>The accident, incident and open disclosure policy states that relatives are to be informed of any incident or accident. The form used to record an incident, accident or near miss allows for documentation of disclosure to family. Thirteen of</p>	<p>Seven incident forms of the 20 reviewed did not include evidence that family had been informed and the progress notes checked did not confirm that family had</p>	<p>Ensure that relatives are informed of any incident or accident as per policy.</p>

information and open disclosure from service providers.		twenty incidents in January 2021 and December 2020 included documentation as to whether the family had been contacted.	been informed.	90 days
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Moderate	Some policies and procedures have been reviewed; however, others have not been reviewed for over three years. Some policies have not been updated to reflect current legislation (e.g., the privacy policy, complaints policy, and health and safety policy).	Policies have not been reviewed at frequent intervals or to reflect changes in legislation.	<p>Review policies as per schedule and to reflect changes in legislation.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate,</p>	PA Low	Staff meetings are held to discuss aspects of the quality programme. In the past there were registered nurse meetings, however these have not been held for over 18 months. Complaints and restraint are not always discussed and there is limited discussion around data tabled.	There is little discussion of data tabled at the staff meeting.	<p>Ensure that meeting minutes reflect discussion of clinical and other quality data including (but not limited to) restraint and complaints when this is tabled.</p> <p>90 days</p>

consumers.				
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	The service has an internal audit schedule. The service has completed some audits as per schedule however some have not been completed since 2018.	Not all audits have been completed as per schedule.	<p>Ensure that audits are completed so that service delivery can be monitored as per schedule</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Moderate	When audits have been completed and issues are identified, corrective action plans are documented. Not all show evidence of resolution of issues.	Resolution of issues when identified in corrective action plans is not documented.	<p>Document evidence of resolution of issues when identified in corrective action plans.</p> <p>90 days</p>
<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</p>	PA Moderate	There is a TIS form documented by a staff member when an incident occurs. The incident forms reviewed related to incidents documented in the progress notes. The incident forms reviewed for December 2020 and January 2021 did not show evidence of review by the nurse manager, or evidence of investigations and remedial actions being implemented as required. Two of 20 incident forms reviewed did show evidence that the nurse manager had reviewed the incident with these closed with documentation in the progress notes related to actions taken to	<p>(i). Eighteen of 20 incident forms (December 2020 -January 2021) reviewed did not show evidence that the nurse manager had reviewed the incident, or evidence of investigations and remedial actions being implemented as required.</p> <p>(ii). Five of eight unwitnessed falls did not have neurological observations taken.</p>	<p>(i). Ensure the incidents are reviewed and close out incidents documented on TIS forms in a timely manner. Ensure documentation reflects that investigations and remedial actions have been implemented as required. (ii). Ensure neurological</p>

improve service delivery, and to identify and manage risk.		ensure that a similar incident did not occur for that resident again. Neurological observations are not all completed as per policy.		observations are completed where the resident has hit their head or potentially hit their head. 60 days
Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.	PA Low	The service has a documented admission policy and process. Not all resident admission agreements reviewed had been signed.	Four of seven resident files admitted between June and December 2020 did not have admission agreements completed and signed by service, resident or family.	Ensure admission agreements are fully completed and signed by the service, resident and/or family as per policy. 90 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the	PA Moderate	Policies are in place to safely manage medication administration. Registered nurses and care staff are responsible for medication administration. Not all care staff involved in the administration of medication had a medication competency.	Three of three caregivers interviewed who were involved in checking and signing for medication (including controlled drugs) had not completed a medication competency.	Ensure all staff involved in the medication administration process are competent to perform the stage in which they are involved.

function for each stage they manage.				30 days
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Moderate	Medication charts included the date started for all medications and stopped where relevant. All charts sampled were legible but did not evidence they had been reviewed three-monthly. The service could not provide a documented schedule of GP reviews at the time of audit however, the nurse manager stated that they 'just knew' when reviews were due as they had worked for a long time in the service. Not all medication charts had correct instructions regarding the administration of crushed medications.	<p>(i). Four of four medication charts reviewed did not contain the required documented indications/instructions re crushed medications.</p> <p>(ii). Three monthly GP reviews could not be evidenced for thirteen of fourteen medication charts reviewed</p>	<p>(i). Ensure all resident medication charts are fully completed with indications/instructions re crushed medications.</p> <p>(ii). Ensure all medication charts are reviewed at least three monthly and that this is clearly evidenced</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Moderate	The kitchen was observed to be clean, and meals well presented. The nurse manager advised the service had applied for a food control plan assessment over 18 months ago but had not had it completed at the time of audit. Not all aspects of food control and kitchen management were being implemented, for example temperature measurement of cooked food.	<p>(i). There were no records of food temperatures being monitored and recorded and a resident fridge was outside the acceptable temperature range (between 8°C and 10°C) daily for over a month with no corrective actions.</p> <p>(ii). A food control plan has not been verified.</p>	<p>(i). Ensure food temperatures are monitored and documented and corrective actions are undertaken to maintain food safety.</p> <p>(ii). Ensure that a food control plan is verified.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service</p>	PA Moderate	The service has documented and contractual timeframes for the completion of resident assessments. Not all assessments were	Three of seven files reviewed did not have an initial interRAI assessment completed, and one of seven files reviewed did not	Ensure all resident assessments, including interRAI and

provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		completed within the required timeframes including interRAI assessments and specialised assessments. Four of seven had assessments completed in a timely manner. Ten specialised assessments were not completed in a timely manner.	have the initial interRAI completed within the required timeframe of 21 days of admission. Ten specialised assessments were not completed in a timely manner as per policy.	specialised assessments, are completed within the required timeframes. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Three of the seven long-term care plans reviewed showed no evidence of resident and family/whānau involvement in the care plan process. Resident files did demonstrate service integration and there was evidence of allied health care professionals involved in the care of the resident including: physiotherapist, podiatrist, wound care nurse specialist and MHSOP	Three of the seven long-term care plans reviewed showed no evidence of resident and family/whānau involvement in the care plan process	Ensure there is documented evidence that residents and/or family are involved in the care planning process. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment	PA Moderate	All seven resident files reviewed have a documented care plan in place. Care staff interviewed were very knowledgeable regarding care and support needs for the residents. The majority of residents and relatives interviewed commented positively about the care received. Care interventions were not documented for all aspects of care including assessed needs.	Interventions to manage identified care needs were not well documented. Example: (i) De-escalation techniques/interventions to manage behaviours that challenge were not documented for one rest home and one hospital level care resident; (ii) One hospital resident with sustained weight loss did not have interventions to reflect increased frequency of weight monitoring, nutritional supplementation or dietitian input; (iii) One hospital level resident had pain and continence issues triggered in the	Ensure that care plans reflect resident need and provide care interventions to manage care. 30 days

process.			interRAI assessment, but interventions to monitor/manage pain and continence were not well documented.	
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	PA Low	Chemicals were stored safely in locked sluices and cleaners' cupboards. The laundry contained chemicals that were not stored safely in a locked cupboard/room. A corrective action plan to remedy this was commenced on day of audit. A bucket of corrosive bleach powder was readily accessible in the laundry as were liquid laundry machine chemicals in an open, non-lockable cupboard.	Chemicals are stored in an open, non-lockable cupboard. A corrective action plan to remedy this was commenced on day of audit.	<p>Ensure all chemicals are stored safely in a manner not accessible to residents and visitors.</p> <p>90 days</p>
<p>Criterion 2.2.4.2</p> <p>Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and</p>	PA Moderate	Frequency of monitoring of restraint is expected to be documented in the care plan. This did not occur in two of two files reviewed where restraint was used. One incident form reviewed along with subsequent documentation in the resident record showed a potentially serious event that was managed by staff on duty who were with the resident when the event occurred. There was no documentation of frequency of monitoring of the restraint documented in the care plan. Staff tick in the progress notes to confirm that restraint has been used during the shift. The time the restraint	(i). Frequency of monitoring of restraint is not documented in the care plan when restraint is used or for each restraint used if more than one restraint is in use for an individual resident. (ii). Documentation of the time the restraint was put on and taken off and evidence of times monitored is not recorded adequately in the resident record.	(i). Document frequency of monitoring of restraint in the care plan. (ii) Document records of monitoring of the use of restraint for individual devices and residents including time on and off and time the restraint was checked.

risk of the restraint being used and the needs of the consumers and/or family/whānau.		was put on and taken off and frequency of monitoring is not documented.		60 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.