Taumarunui Community Kokiri Enterprises Limited - Te Arahina O Arihia Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Taumarunui Community Kokiri Enterprises Limited
Premises audited:	Te Arahina O Arihia Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 March 2021 End date: 16 March 2021

Proposed changes to current services (if any): HealthCERT requested the reconfiguration of a storage room into a bedroom in 2019 be included in this report increasing the total number of beds from 15 to 16.

Total beds occupied across all premises included in the audit on the first day of the audit: 11

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

Te Arahina O Arihia Lifestyle Home provides residential services at rest home level for up to 16 residents. The facility is operated by Taumaranui Community Kokiri Trust and is managed by a manager.

Residents and families/whānau reported satisfaction with the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families/whānau, manager, staff and a general practitioner.

Systems have not been maintained following the previous audit. Areas requiring improvement relate to resident and staff meetings, resident satisfaction surveys, the internal audit programme, quality data reported back to staff, corrective actions, annual practising certificates, reference checking, ongoing training, competency assessments, communication with family/whānau, currency of resident care plans, medical notes, currency of interRAI assessments, review of the menu by a dietitian, monitoring of hot water temperatures, security of sluice rooms, emergency water supplies and approval of the fire evacuation scheme.

Consumer rights

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

A complaints register is maintained with complaints resolved promptly and effectively. There have been no complaints investigated by external agencies since the previous audit.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services at Te Arahina O Arihia Lifestyle Home are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families/whānau is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

Organisational management

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

Taumaranui Community Kokiri Trust is the governing body and is responsible for the service provided. Business and quality and risk management plans include a mission statement, business objectives and values. The manager provides reports to the board on a variety of activities concerning the service.

The service is managed by a manager who is supported by a registered nurse and the trust board.

There is an internal audit programme in place. Quality data is collected and analysed for trends. Adverse events are documented on adverse events forms and entered electronically.

Actual and potential risks, including health and safety risks, are identified and mitigated.

Policies and procedures on human resources management are in place. An in-service education programme has been developed and staff performance is monitored.

There is a documented rationale for determining staffing levels and skill mix. Staff are rostered on call after hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using integrated electronic and hard copy files.

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.

Te Arahina O Arihia Lifestyle Home liaises with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family/whānau to facilitate the admission.

Residents' needs are assessed on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Short term care plans are developed to manage any new problems that arise.

Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is run by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by the registered nurse or care staff, all of whom have been assessed as competent to do so.

Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised and clean. Residents verified overall satisfaction with meals.

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 at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

Adequate numbers of bathrooms and toilets are available throughout the facility. There are several lounges, dining area and alcoves. External areas for sitting and shading are provided.

An appropriate call bell system is available and residents reported timely responses to call bells. Security and emergency systems are in place. Staff are trained in emergency procedures. Fire evacuation procedures are held six monthly.

Protective equipment and clothing are provided and used by staff. Linen and equipment were safely stored. All laundry is undertaken on site and the cleaning and laundry are evaluated 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.		Standards applicable to this service fully attained.

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using a restraint and two residents using an enabler at the time of audit. Enabler processes meet the standard.

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 prevention and control programme, led by the registered nurse and the manager aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from the district health board.

The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken and analysed. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	35	0	3	7	0	0
Criteria	0	79	0	6	8	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	Te Arahina O Arihia Lifestyle Home (Te Arahina) has policies and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' 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 employed and in ongoing training, as was verified in 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 understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff were observed to gain consent for day-to-day care on an ongoing basis.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family/whānau members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service.
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 are assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' families/whānau and friends. Family members/whānau interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families/whānau on admission and complaints information and forms are available at the main entrance. Two complaints have been received since the last audit and these have been entered into the complaints register. Complaint documentation was reviewed and actions taken 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. The manager is responsible for complaint management and follow-up. Staff interviewed confirmed an understanding of the complaints process and what actions are required. There have been no investigations by external agencies since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family/whānau interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.

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	Residents and families/whānau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families/whānau and the general practitioner (GP) or nurse practitioner (NP). All residents have a private room. Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing, was documented in the resident's activity plan. Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into the resident's daily activity plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, however, has not been provided on an annual basis, as confirmed by staff and training records (refer criterion 1.2.7.5).
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	There were four residents in Te Arahina at the time of audit who identified as Māori, and seven staff members. Interviews verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values,	FA	Residents and their family/whānau members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and special needs were included in the care provided, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire had not been undertaken (refer criterion 1.2.3.1).

and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family/whānau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A GP also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. The registered nurse (RN) has recently finished completing the RN competence assessment programme (CAP) and records of completion includes the required training on professional boundaries. Staff are provided with a code of conduct as part of their individual employment contract. Ongoing education has not been completed on an annual basis, as confirmed in staff training records (refer criterion 1.2.7.5). Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, practice nurses, nurse practitioner, district nurses, Waikato District Health Board (WDHB), Taumaranui Hospital and mental health services for older persons. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Examples of good practice observed during the audit included a commitment to improving timely services to resident. Phlebotomy services in the past have been difficult to access at Te Arahina. The RN has been trained by the staff at Taumaranui Hospital and verified as competent to offer phlebotomy services to the residents of Te Arihina. Other examples of good practice include the recent introduction of an electronic nursing and quality management system aimed at improving systems to improve compliance, and the commitment to the needs of Maori residents regarding cultural etiquette and meeting their dietary needs, for example; providing food choices that are particularly relevant to Maori residents.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	PA Low	The resident numbers in Te Arihina are small and the manager and several staff have been working there for some years. The environment is one of familiarity within a small rural community, where people are known. Residents and family/whānau members, however, stated they were at times not well informed about any changes to their relative's status and were often not advised in a timely manner about any incidents or accidents and outcomes of regular medical reviews. This

communication.		was supported in residents' records reviewed. Staff members were not wearing name badges; therefore, family members, visitors or other staff have difficulty in identifying who they were talking to. There was no documented evidence of resident/family/whānau input into the care plan (Refer criterion 1.3.5.2). These are areas that require improvement. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via WDHB when required and staff knew how to do this. Several residents spoke Maori and were supported by staff or the local community, if there were any communication difficulties due to language barriers. Staff reported interpreter services were rarely required due to all present residents being able to speak English or Maori.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Moderate	Te Arahina O Arihia Lifestyle Home is governed by a trust board of five members who meet monthly. The trust board is responsible for setting the strategic direction and the service at the facility. The business plan 2019-2021 has a mission statement, business objectives and values, strengths, weaknesses, opportunities and threats. The manager presents and/or provides reports to the board at their board meetings. The reports include but not limited to staffing, occupancy, training, complaints, adverse events, and any major changes. Review of the manager's reports and interview of the manager confirmed this. The facility is managed by a manager who has been in the position since September 2015. The manager is also responsible for human resource management for the trust. The manager is supported by the trust board and the registered nurse (RN). The RN has been in the role for three months and is new to the age care sector in New Zealand. They completed a competency assessment programme (CAP) prior to this appointment. Prior to the current RN commencing employment, there have been two RNs employed since the previous audit with gaps in between employment filled by the practise nurses and the nurse practitioner (NP). The current RN is being mentored by the NP with six weekly supervision sessions and peer support meetings. The RN is also provided with support from the practise nurses. The RN has completed an orientation by the manager and the NP. A storage room has been reconfigured into a single bedroom. This change occurred in 2019 and the bedroom is now occupied. Te Arahina O Arihia Lifestyle Home is certified to provide rest home level care. The service provider has contracts with the DHB for age related residential care services (ARRC) and respite services. On the day of audit there were eight residents under the ARRC contract and three residents (two under the age of 65 years and one over 65 years) who have individual contracts

		with the Ministry of Health (MoH).
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	If the manager is absent, the chief executive officer will fill the role. During the absence of the registered nurse (RN), the practise nurses are available to cover for the clinical service.
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 Moderate	The Quality and Risk Management policy includes a quality framework, quality objectives with reviews. An impact scale relates to the levels of risk. Quality data is managed by the manager who enters it into an electronic programme provided by an external company. However, aspects of the quality programme have not been maintained since the last audit. Some quality data is collated and analysed for any trends. The internal audit programme for 2020 and 2021 have not been followed and there have been no audits completed for 2021. Corrective actions have not been consistently developed and implemented and reported to staff. Graphs are generated and include benchmarking; however, staff were not aware of these. Staff and resident meetings are not held regularly. Resident/family/whānau satisfaction surveys have not been undertaken. Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are reviewed and updated by the external company who provides them and were current. Obsolete policies are destroyed. Staff are notified via memos and the communication book of reviewed and updated/new policies. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery. A risk management plan includes a risk assessment matrix. The hazard/risk register includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risks. Hazards are entered onto an adverse event form. The hazard/risk register includes actual and potential hazards and the actions put in place to minimise or eliminate the hazard. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood and implemented documented hazard identification processes.

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	Adverse, unplanned or untoward events are documented by staff on adverse event forms and reviewed by the RN and manager who investigates and develops and implements any corrective actions if needed. The manager enters the data into the electronic programme. Documentation reviewed and interviews of staff indicated appropriate management of adverse events apart from communication with families/whānau (Link to criterion 1.1.9.1) Policies and procedures comply with essential notification reporting. 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 and other documentation confirmed this. The manager reported there have been no Section 31 notifications to HealthCERT since the previous audit.
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 Moderate	Policies and procedures relating to human resources management are in place. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, orientation, education records and police vetting. None of the staff files evidenced any references. An orientation workbook is generic and role specific and includes competencies. The workbook is completed within three months of employment. Staff performance is reviewed at the end of this period. Orientation for staff covers all essential components of the service provided. An in-service education programme is in place and covers all required subjects, however, the programme has not been followed. Apart from fire drills undertaken in 2020 and 2021, there has been no ongoing training provided. Attendance records are maintained. Care staff have not completed at least eight hours of ongoing training. Competencies are current for staff who are responsible for medication management, however competencies for staff who are second checkers for controlled drugs have not been completed. There was no evidence of restraint competencies. The RN is not interRAI trained and is booked to complete the course in April 2021. There is a staff member on each shift who has a current first aid certificate. A New Zealand Qualification Authority education programme is available for staff to complete and they are encouraged to do so. Two care staff have attained level 2 and three have attained level 3. The diversional therapist has attained level 4. Staff performance appraisals were current. Apart from the RN, annual practising certificates were not available for staff or contractors who require them to practice. Staff interviewed confirmed they have completed an orientation, including competency

		assessments and their performance appraisals are current. Staff interviewed confirmed on-going training has been spasmodic and stated they had not received any for some time.
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 mix to provide safe service. The manager is responsible for rostering of staff and reported that staffing is stable. The roster is reviewed continuously and dependency levels of residents is considered. The manager and the RN are fulltime Monday to Friday, eight hours a day. There are two care givers on each shift. The RN and two of the four practise nurses are on call. Laundry and some cleaning is undertaken by the care staff. A dedicated cleaner workers five hours a day, Mon to Friday. A diversional therapist works four hours a day Monday to Friday. The maintenance and external environment is undertaken by the personal from the trust. Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and families/whānau reported they are happy with the staffing levels and there are enough staff on duty to provide them or their relative with a good standard of care.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. 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. Electronic nursing and medication records are stored in a secure portal.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families/whānau are encouraged to visit the facility prior to admission and meet with the manager or the RN. They are also provided with written information about the service and the

their need for services has been identified.		admission process. Family/whānau members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the WDHB emergency care form for aged related residential care residents to facilitate transfer of residents to and from acute care services. There is open communication between all services. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner.
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	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. There is no second checker competency at Te Arahina (refer criterion 1.2.7.5). The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN)

		medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart. There were no residents who self-administer medications at the time of audit. Medication errors are reported to the RN and the manager and recorded on an accident/incident form. No evidence of medication errors was sighted. Interview's evidence there is a process for comprehensive analysis of any medication errors. Standing orders are not used at Te Arahina.
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	The food service is provided on site by a cook; however, the menu has not been reviewed by a dietician since March-2017. A food control plan issued by Ruapehu District Council expired in May 2020. The renewal audit was not undertaken due to Covid-19. The visit then took place on the 31st of July 2020, however, there has been no report received. These areas require attention. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, and food to meet resident's nutritional and cultural needs, is available. Evidence of resident satisfaction with meals is verified by resident and family/whānau interviews. Any areas of dissatisfaction were promptly responded to, and residents were offered alternatives. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.
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	FA	If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family/whānau are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the manager. There is a clause in the access

appropriate.		agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	On admission residents of Te Arahina are initially assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, and depression scale to identify any deficits and to inform initial care planning. At the time of audit, residents of Te Arahina are not being assessed within three weeks of admission using the interRAI assessment tool. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, is not occurring every six months or more frequently as residents changing conditions require. Interviews, documentation, and observation verifies the RN is familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels. The RN is not interRAI trained, however is enrolled for interRAI training to take place in April 2021. No residents have current interRAI assessments. InterRAI assessments are not used to inform the care plan. This is an area requiring attention and the manager and RN are aware of this
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Interviews and observations verify residents are receiving the care required to meet their generalised day to day needs. A review of five resident files however evidenced there was no documented plan of care in place that described the required support needed to meet the resident's needs. Four of the five care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed. These however had not been updated since February 2020. The fifth file reviewed had an initial care plan and no long-term care plan in place. The absence of up to date care plans did not evidence service integration with progress notes, activities note, medical and allied health professional's notations clearly written, informative and relevant. This requires corrective action. Any change in care required was documented in the progress notes and verbally passed on to relevant staff.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations, and interviews verified the provision of care provided to residents was consistent with their needs and goals. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a good standard. Care staff confirmed that care was provided as outlined in the communication book and verbal orders. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
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.	FA	The activities programme is provided by a diversional therapist, who works four hours a day five days a week. A social and cultural assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and every six months. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included exercises, games, crafts, hobbies, church services visiting entertainers, quiz sessions and daily news updates. There have been no residents' meetings since March 2020 (refer criterion 1.1.9), however the diversional therapist says residents' feedback regularly regarding satisfaction/dissatisfaction with the service. Areas of dissatisfaction are responded to. Residents interviewed confirmed they find the programme meets their needs.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations do not occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change (refer criterion 1.3.4.2). Evaluations are documented by the RN in the progress notes. Where progress is different from expected, the service responds by initiating changes to the care provided or seeking GP or NP advise. Examples were sighted of a short-term care plan being consistently reviewed for a skin infection and progress evaluated as clinically indicated. and according to the degree of risk noted during the assessment process.

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 to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
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 are in place. Incidents are reported in a timely manner. Safety data sheets were sighted and are accessible for staff. The hazard register was current. Protective clothing and equipment were sighted that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed demonstrated an understanding of 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 is displayed at the front entrance. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for purpose. Residents and families/whanau confirmed they can move freely around the facility and that the accommodation meets their or their relative's needs. Passageways have adequate room for residents to pass comfortably. There is a proactive and reactive maintenance programme, and the buildings, plant and equipment are maintained to an adequate standard. Maintenance is undertaken by maintenance people from the trust. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. Hot water temperatures have not been monitored at resident outlets. The bedroom created from a storage room did not require any structural alterations. The room is large with a wardrobe and bedside table. A call bell has been installed and heating is appropriate. The room is fit for purpose. The facility is situated in spacious grounds. Seating and shade is available for residents to frequent. The environment is conducive to the range of activities undertaken in the areas.

		Residents are protected from risks associated with being outside. Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. Separate bathrooms for staff and visitors are available.
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 personal space provided to allow residents, staff and any equipment to move around within the bedrooms safely. Rooms are personalised with furnishings, photographs and other personal items on display. The storage room changed into a bedroom is large, has a call bell and heating and is fit for purpose. There is adequate room 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	Various communal areas are available for residents to frequent. The dining and lounge areas have good space and enable easy access for residents and staff. Residents can access areas for privacy. The furniture in the lounges and dining room is appropriate to the setting and residents' needs. There is adequate space to accommodate wheelchairs in the dining room and lounges.
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	PA Moderate	All laundry is undertaken on site. The cleaner and care staff demonstrated knowledge of the cleaning and laundry processes. The cleaning of the facility is to an adequate standard. The cleaning trolleys are stored securely when not in use. The representative from the chemical company visits the facility regularly. Residents and families/whānau interviewed reported personal clothes are managed effectively and returned in a timely manner. Cleaning and laundry processes

service is being provided.		are monitored through the internal audit programme. Both sluices were observed to have chemicals stored within and remained unlocked during the days of audit.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate	The manager stated the current fire evacuation plan has been approved by the New Zealand Fire Service, however, evidence of this was unavailable. Fire evacuation training has been held and the fire drill takes place six monthly with a copy sent to the New Zealand Fire Service. The orientation programme includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures. Policies and procedures and guidelines for all emergency planning, preparation and response are displayed and flip charts are displayed throughout the facility to guide staff. Disaster and civil defence planning guides direct the facility in their preparedness for disasters and described the procedures to be followed in the event of a fire or other emergency. Monitoring of civil defence supplies is the responsibility of the manager. Adequate supplies for use in the event of a civil defence emergency including food, blankets, torches, mobile phones and a gas barbecue were sighted and meet the requirements for the number of residents able to be accommodated at the facility. Water storage does not meet the requirements for the emergency water storage recommendations for the Waikato region. Call bells alert staff to residents requiring assistance. Call bells were observed in service areas within the facility. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the facility is checked by staff. Sensor lights are situated externally.
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 under floor heating and four heat pumps. 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/whānau reported the temperature is always comfortable. The building is smoke free and a covered area outside is provided for people who smoke.
Standard 3.1: Infection control	FA	The service provides a managed environment that minimises the risk of infection to residents,

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.		staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the RN and manager. The infection control programme and manual are reviewed annually. The RN with input from the manager is the designated infection control nurse (ICN), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported to staff at handover each day and monthly to the board. Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.
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 ICN has appropriate skills, knowledge, and qualifications for the role, however, has been in this role for only a short time and is being assisted by the manager. The ICN has undertaken training in infection control during the CAP training. Well-established local networks with the infection control team at the DHB, the local medical practice and public health are available if additional support/information is required. The RN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The ICN and manager confirmed the availability of resources to support the programme and any 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 IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year 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, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. 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	Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation however not at ongoing education sessions (refer criterion 1.2.7.5). When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent risk associated with Covid-19. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.
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	Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The RN and manager review all reported infections. The number of infections at Te Arahina is low with none in the past four months. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are not shared with staff via quality and staff meetings (refer criterion 1.2.3.6). Staff are informed at handover. A good supply of personal protective equipment is available. Te Arahina has processes in place to manage the risks imposed by Covid-19.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There were no residents using restraint and two residents using an enabler on the days of audit. Policies and procedures have definitions of restraints and enablers. Resident's files evidenced signed consent by the resident, assessments and evaluations. Staff demonstrated knowledge about restraints and enablers and knew the difference between the two.

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 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	There are a small number of residents in Te Arihina and the manager and several staff members have been working there for some years. The environment is one of familiarity within a small rural community, where people are known. Name badges at Te Arahina were not provided, and visitors and new residents were unable to identify the name, or the title of the person being spoken to. Interviews identified this was due to budgetary constraints, and sharp badges could cause injury to residents. There was no documented evidence of residents or families/whānau having input into the care plans (refer criterion 1.3.5.2), or contact following medical reviews or changes in the residents’ condition. A review of four recent incidents, had no documentation verifying the family had been contacted, one family member had been told when visiting four days later. There have been no residents’ meetings since March 2019, to enable resident input (refer criterion 1.2.3.1). The staff did, however, remark that residents and family/whānau members spoke to them informally at most	The environment at Te Arihina did not evidence a setting that was conducive to effective communication.	Provide evidence the environment is conducive to open communication by providing name badges, including family/whānau in care planning, keeping family/whānau informed and holding regular residents’

		visits. Any concerns they would take to the manager or RN.		meetings. 90 days
Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.	PA Moderate	A robust quality and risk management system, provided by an external company, has been in place since 2017. The internal audits for 2020 and 2021 have not been completed. Audits undertaken in 2020 included care planning, which was partly completed, food satisfaction, cleaning and laundry services and health and safety. Infection prevention and control and medicine management audits were last completed in 2019. There have been no internal audits completed so far for 2021. Staff meetings are scheduled to be held monthly, however, three only have been held between May 2020 and March 2021. Review of the staff meeting minutes evidenced the template included in the quality programme is not being utilized and the minutes do not evidence any reporting of quality data back to staff. Staff interviewed confirmed this. One resident meeting minutes was sighted and this was dated 26 March 2019. No other minutes were available and staff reported there have not been any other meetings held. No resident/family/whānau satisfaction surveys were available for review and the manager reported these have not been undertaken.	(i)The internal audit programme has not been followed for 2019, 2020 and 2021. (ii)Staff and resident meetings have not been held regularly. (iii)No evidence available for resident/family/whānau satisfaction surveys.	Provide evidence that (i)the internal audit programme is followed, (ii)staff and resident meetings are held regularly and minutes kept, (iii)resident satisfaction surveys are completed. 60 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate,	PA Moderate	Some quality data is being collected and analysed for any trends. This includes but not limited to clinical indicators such as falls, skin tears and infections. Review of the staff meeting minutes evidenced the template included in the quality programme is not being utilized and the minutes do not evidence any reporting of quality data back to staff. Staff and the manager interviewed confirmed this.	Not all quality data is being collected, collated and analysed to identify any trends and reported back to staff.	Provide evidence that all quality data is collected, collated and analysed and reported back to staff. 60 days

consumers.				
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	Corrective actions have been developed and implemented for adverse events and any trends identified through analysis of clinical indicators. Corrective actions for internal audits evidenced a mix of actions. Some were documented with no evidence of completion and sign off. Others had no corrective actions where deficits were identified.	Corrective action plans are inconsistently developed, implemented, reviewed and signed off.	Provide evidence that where a deficit is identified, a corrective action is developed, implemented, reviewed and signed off. 60 days
Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	Review of the RN's file evidenced their practicing certificate is current. Current practising certificates for any other staff member and contractors were not available for review, including practise nurses, nurse practitioner, GPs, dietitian and pharmacist.	Evidence of current practicing certificates for staff and contractors who require them to practice were not available.	Provide evidence that all staff and contractors who require practicing certificates to practice are held on site. 30 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of	PA Low	Policies are in place for the recruitment and employment of staff. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, orientation, education records, and police vetting. However, none of the files evidenced any references. One file held general references that were not specific to the position applied for.	None of the staff files reviewed have evidence of reference checking.	Ensure all staff have reference checks prior to employment. 30 days

consumers.				
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	The in-service education programme reviewed evidenced all subjects required are covered. The programme has not been followed and there has been no ongoing training undertaken in 2020 and 2021 apart from fire training and drills. The Code and the ageing process which are biennial were provided in 2019 and are due again this year. Medication management training was last provided in 2016 and infection prevention and control in 2019. Most ongoing trained was provided in 2017. Care staff have not completed at least eight hours of ongoing training per annum. Attendance records are maintained. Staff who are responsible for medication management have current competencies, however competencies for staff who are second checkers for controlled drugs have not been completed. There was no evidence of restraint competencies. The RN is not interRAI trained. However, is booked to complete the course in April 2021. There is a staff member on each shift who has a current first aid certificate. Several staff have first aid certificates that have expired and are booked to update their certificates. A New Zealand Qualification Authority education programme is available for staff to complete and they are encouraged to do so. Two care staff have attained level 2 and three have level 3. The diversional therapist has attained level 4.	The education programme has not been followed and most ongoing training occurred in 2017. Care staff have not completed eight hours of ongoing training. Competencies relating to second checkers for controlled drugs and restraint were not available.	Provide evidence that (i) ongoing training programme is provided to staff, (ii) care staff have current competencies for second checkers and restraint. 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	PA Low	The food service is provided on site by a cook; and the residents and family/whānau/ were complimentary of the food service, however, the menu has not been reviewed by a dietician since March 2017 and therefore has not been verified as in line with recognised nutritional guidelines for older people. There is no up to date food control plan on site, despite an audit in July 2020.	There is no evidence the nutritional needs of residents are in line with recognised nutritional guidelines.	Provide evidence a dietician has reviewed the menu and it meets the guidelines. Provide evidence an up to date food control plan is in place at Te

group.				Arahina. 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	Five files reviewed had initial assessments and initial care plans completed however there was no evidence of an up to date interRAI assessment being undertaken to inform the care plan and form the basis of services delivery in all five files. The RN is not interRAI trained and cannot complete the assessments.	None of the resident files reviewed had evidence of an up to date interRAI assessment.	Provide evidence the RN has completed the interRAI training. Provide evidence all residents have ongoing and up to date assessments using the interRAI assessment tool. 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	In four of five files reviewed, there were documented long term care plans in place to describe the required support the resident needed to meet the desired outcomes. These however, had not been updated since February 2020 to ensure they accurately reflected the residents changing needs. The fifth file had no long-term care plan in place. One of five files had no medical consultation notes on site, as the medical practice saw the resident off site but did not send through the consultation notes. The required nursing interventions to manage potential problems associated with the medical diagnosis was not documented in the resident's notes. A resident diagnosed with congestive heart failure (CHF), had no documentation concerning the nursing observations required to detect potential deterioration. Progress notes record increase swelling, however, this	Residents have no long-term care plans in place to describe the required support the resident needs to meet the desired outcomes.	Provide evidence all residents have care plans in place that describe the required support the resident needs to achieve the desired outcome.

process.		has not been associated with deteriorating CHF until the resident is acute and requires admission to the DHB. A resident of high risk of falls, has one-to-one observation in the morning, however there is no care plan documenting the management strategy for minimising the falls risk. A resident who has recently had a fall and a bang on the head, has no RN assessment documented post fall and no evidence of neurological observations. The RN verifies this did occur however there is no evidence. A resident with a substantial weight loss has no documented management plan, despite interviews and evidence verifying it is being managed. Multi-disciplinary reviews of the resident no longer occur.		90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	A current building warrant of fitness is displayed at the front entrance that expires on the 20 May 2021. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. Apart from hot water temperatures monitored and recorded in March 2021, monitoring has not been undertaken. Recording of temperatures taken evidenced there were temperatures exceeding 45 degrees celsius. An electrician has lowered the temperatures and documentation reviewed evidenced all hot water at resident outlets is now 45 degrees or under.	Hot water temperatures at resident outlets have not been monitored until March 2021.	Provide evidence that all hot water at resident outlets is monitored and recorded regularly. 60 days
Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Moderate	Both sluices have chemicals stored on shelves and have a keypad lock to ensure the sluices are secure. Several observations during the audit evidenced the sluices remained unlocked throughout the two days on site.	The sluices have chemicals stored in them and although they are fitted with keypad locks, they are not kept locked when not in use.	Ensure that the sluices are kept locked at all times when not in use. 1 days

Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Moderate	Fire evacuation training was last held 12 March 2021 and the fire drills are undertaken six monthly with a copy sent to the New Zealand Fire Service. Documentation reviewed confirmed this. The orientation programme includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures. Fifteen litres of water was evidenced for residents and staff for use in an emergency. Water storage supplies do not meet the requirements for the emergency water storage recommendations for the Waikato region. (3 litres of water per person per day for 7 days).	The supply of water is not adequate for the number of residents and staff to use in an emergency.	Provide evidence that the supply of water is adequate for the number of residents and staff to use in an emergency. 7 days
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Low	The manager stated the current fire evacuation plan has been approved by the New Zealand Fire Service. However, a copy of the fire evacuation scheme was not available for review during the audit.	A copy of the fire evacuation scheme approval letter from NZ Fire Service was not sighted	Provide evidence that the fire evacuation scheme has been approved. 30 days

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.