Logan Samuel Limited - Anne Maree Gardens

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:	Logan Samuel Limited
Premises audited:	Anne Maree Gardens
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 17 March 2021 End date: 18 March 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 72

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

Anne Maree Gardens provides rest home, hospital level, psychogeriatric and residential disability care for up to 79 residents. The service is operated by Logan Samuel Limited and managed by a general manager, manager, and a clinical lead. Residents and families spoke positively about 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 records, observations and interviews with residents, family members, managers and staff and a general practitioner.

The audit has resulted in two continuous improvement ratings related to complaints management and the activities programme. Five areas were identified as requiring improvement including service provision in regards to the timeliness of interRAI re-assessments and post falls management and required observations, medicine management of PRN medicines and staff medication competencies and one improvement in relation to infection prevention and control.

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.		All standards applicable to this service fully attained with some standards exceeded.

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

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

The residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The service has linkages with a range of specialist health care providers in the community.

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

The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

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.		Standards applicable to this service fully attained.

Logan Samuel Limited is the governing body and is responsible for the service provided at this facility. A business plan and quality and risk management plans are documented and include the scope, direction, goals, values and mission statement of the organisation. Robust systems are in place for monitoring the services provided including regular daily, weekly and monthly reporting by the manager to the governing body. Anne Maree Gardens is one of two aged care services owned by the same organisation.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse.

A quality and risk management system is in place which includes and annual schedule of internal audits activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident, family and staff satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where applicable. Meeting minutes, graphs of clinical indicators and benchmarking results are available and were reviewed. Corrective action plans are developed, implemented, monitored and signed off when completed. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated, and the hazard register is current and up to date.

A suite of policies and procedures cover the necessary areas, were current and reviewed regularly by a quality consultant.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation/induction and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan, facilitate and record ongoing training supports safe service delivery, and includes regular individual performance review.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents are met. There is an on-call after-hours system in place.

Residents' information is kept securely with all entries legible and designated.

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.

Needs Assessment Service Coordination (NASC) team assess residents prior to entry to confirm their level of care. Assessments and care plans are completed and evaluated by the registered nurses (RNs). Short term care plans are developed for all acute problems and these were verified in records sampled.

Activities plans are completed by a diversional therapist (DT) assisted by two activities coordinators currently studying for a level four DT course. The activities programme is developed in consultation with family/whanau and residents noting activities of interests. Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management policy in place. The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The facility has been purpose built. There are all single rooms, with the exception of one double room, including some rooms with ensuite bathrooms. All rooms are of an adequate size to provide personal cares.

All building and plant comply with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas in two locations are available with appropriate seating for residents.

Implemented policies and procedures guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken off site with systems monitored to evaluate effectiveness. Cleaning is managed on site, meets all requirements, and is linked to health and safety and infection prevention and control.

Emergency procedures are documented and displayed. Regular six-monthly fire drills are completed and there is a sprinkler system and call points installed in case of fire. Emergency lighting is available and is checked monthly. Emergency stores are available. Residents report a timely staff response to the nurse call system in place. Security is managed effectively onsite.

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 organisation has implemented policies and procedures that support the minimisation of restraint. One enabler and four restraints are in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. Enabler use is voluntary for the safety of residents in response to individual requests. Staff interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.

Infection control management systems are in place to minimise the risk of infection to residents, visitors, and other service providers.

The infection control coordinator is responsible for co-ordinating education and training of staff.

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

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	2	45	0	1	2	0	0
Criteria	2	95	0	1	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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	The organisation has documented policies and procedures to meet their obligation 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 and ongoing training was verified in the training records. Staff training on the Code was last conducted on 19 March 2020. The Code is displayed around the facility and provided to residents and family/whanau as part of the admission process. The Code is discussed at monthly residents' meetings. Documented evidence of this was sighted in the minutes reviewed.
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	FA	The consent policy and procedure references consumer right legislation, including competency/mental capacity. There is also a policy on advance directives. Staff interviewed understood the principles and practice of informed consent. The service was able to demonstrate that written consent is obtained where required. Resident agreements sampled confirmed that informed consent has been gained appropriately. These were signed by the enduring power of attorney (EPOA), or residents, and the general practitioner makes a clinically based decision on resuscitation authorisation if required. The CL reported that written consent was sought on admission about sharing of rooms for residents who are competent to make decisions and EPOAs, respectively. All residents with dementia have activated EPOA in place and this was

consent.		sighted in residents' records reviewed. Staff were observed to gain consent for daily cares. An informed consent questionnaire was completed by staff on 4 March 2020. Interviews with residents and relatives confirmed the service actively involves them in decision making.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	As part of the admission process residents and family/whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the Nationwide Advocacy Service were displayed and available in the facility. Family members and residents were aware of the advocacy service, how to access this and their right to have support persons. The CL and staff provided examples of the involvement of advocacy services in relation to residents' care.
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 and the community by attending to a variety of organised outings, visits, shopping trips, activities, and entertainment. Family/whānau or friends are encouraged to visit or call. The facility has unrestricted visiting hours unless restrictions are required due to either an outbreak at the facility or any current Covid-19 pandemic national alert levels. The service encourages visits from residents' family and friends. Residents reported they can either visit their family in the community or get them to visit them anytime they want. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	CI	The complaints policy (reviewed October 2020) and associated forms meet the requirement of Right 10 of the Code. There is also a flow chart developed and implemented to guide staff. The complaints information is provided to residents on admission and there is complaint information and forms at reception. A complaints/compliments box is also located in the reception area of the facility along with forms and pamphlets on the complaints process. The complaints register reviewed evidenced 137 minor complaints since December 2019 until 22 February 2021. Actions were taken through to an agreed resolution, were fully documented and completed within the required timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible. One complaint was received from the Nationwide Health and Disability Advocacy Service which has been closed out. In addition to this, a further complaint initially received from the Ministry of Health (MoH), was forwarded to the district health board and this complaint

		remains open. The complaint was made by a resident's family. The resident was admitted under the primary options for acute care (POAC) contract. There was a query over a fee to be charged but this was not required, and an explanation was provided to the family by the director. At the time of discharge a medication error for this resident did occur. The complaint was followed through by the director (in the absence of the manager) and with the assistance of the administrator/personal assistant to the manager and this was investigated and managed effectively, and the closure letter was reviewed. Feedback and learning from this complaint was fed back to staff. The complaints management system has been significantly improved. The administrator works closely with the manager and ensures the complaints register is maintained and is current and up to date. The complaints register is comprehensive, and the administrator provides an annual summary and comparative study of improvements from the previous year and a continuous improvement has been awarded for complaints management. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents are informed of their rights during entry to service and through the service delivery process. Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. All residents receive a copy of the Code, this is provided in English and Maori and other languages as appropriate. Interpreters are used as required. Family members and residents interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process. Minutes of residents' meetings were sighted, and these occur monthly. The admission pack outlines the services provided. Resident agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and	FA	There is a policy and procedure regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms and reporting requirements. Staff respect and allow young people living with disabilities to express their personal, gender, sexual, cultural, religious, and spiritual identity. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice. The GP has a designated room where medical consultations and examination were conducted.

independence.		Residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with residents assessed as rest home, hospital, and psychogeriatric level of care. The physiotherapist (PT) visits once a week or as required. The service supported residents who had severe mobility issues up to a stage where they were now mobilising with supervision using specialised walking aids. In interview, the PT reported that active and passive exercises are conducted on all residents to promote and maintain muscle strength. Residents were able to move freely into the surrounding areas and in and out of the facility's secure grounds with no restrictions. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.
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	Assessments and care plans document any cultural and spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. A cultural safety questionnaire was completed on 11 March 2020 by all staff. There is an assessment for Māori residents. Cultural needs are included in the care plans, if identified. There is access to cultural advice, resources, and documented procedures. There were seven residents who identified as Maori and cultural needs were included in their care plans. There was one staff member of Maori descent. Policies and procedures regarding the recognition of Maori values and beliefs are documented.
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, and beliefs.	FA	Cultural needs are identified on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the resident and family/whānau. The service has residents and staff of different cultural backgrounds. Values and beliefs are discussed and incorporated into the care plan. Family members and residents confirmed they were encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans reviewed.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual,	FA	There are documented policies and procedures in place to prevent and minimise incidents of discrimination, coercion, harassment, sexual, financial, or other exploitation at the service. Family members stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Residents interviewed reiterated the same. The induction/orientation process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. A code of conduct statement is included in the staff employment agreement. Staff are guided by policies and procedures and demonstrated

financial, or other exploitation.		a clear understanding of the process they would follow, should they suspect any form of exploitation. The clinical leader (CL) stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed promptness and appropriateness of medical intervention when medical requests are sought. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. The organisation supports and maintains competencies for staff in manual handling, medication administration and interRAI assessments, completing online courses such as infection prevention and control and dementia courses. The facility manager is a Career force assessor. Various quality initiative projects were implemented (e.g., the introduction of the electronic record and medication management systems). Most staff have level three and level four industry approved qualification.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Family members stated they were kept well informed about any changes to their relative's health status, were normally advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Communication continued to be maintained even during Covid-19 pandemic lockdown throughout all national alert levels announced by the Ministry of Health. This was supported by residents and in records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures. Staff completed an open disclosure questionnaire on 27 February 2020, and this was sighted in the individual training records sighted. Interpreter service can be accessed as required on a referral basis and staff knew how to do so if required. There are alternative forms of communication that meet the needs of young people with disability. These include various community groups; family members and staff members can use basic sign language including communication cards. Staff can provide interpretation as and when needed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned,	FA	There is a business plan and quality and management plan for 2021 that is documented for Anne Maree Gardens. A mission statement, statement of purpose and the philosophy of the service is clearly documented. Quality and risk planning is clearly documented with goals and objectives covering provision of quality services appropriate to the needs of the residents, to improve the quality of life of residents, to provide

coordinated, and appropriate to the needs of consumers.		and maintain a safe and healthy environment in the home and to provide a cost effective service that gives value for money while organising resource constraint. The manager interviewed reports to the director weekly about any issues or concerns that have been highlighted Monday to Friday and to the general manager (GM) monthly and/or as needed (the GM was on leave at the time of audit). Staff on in the weekend inform the manager of any emerging risks or issues as required. The service is managed by a manager who holds relevant qualifications in healthcare. The manager has been in this role for 17 years and has worked in the aged care sector in both New Zealand and Fiji. The manager is suitably skilled and experienced for the role and the responsibilities and accountabilities as defined in the job description reviewed. At interview, the manager confirmed comprehensive knowledge of the aged care sector, regulatory and reporting requirements and maintains currency through ongoing management and nursing education as per the training records. The manager is well supported by two directors one of whom is the financial manager, a general manager and an administrator/personal assistant (PA). The service holds contracts with the DHB for rest home level care, hospital level – geriatric, hospital services – medical, residential disability services for younger persons with a disability (YPD) and psycho-geriatric level care. On the day of audit 72 residents are receiving care. Nine psycho-geriatric level care, six younger persons with a disability (two of whom are hospital level and four rest home level care), 19 rest home level care and 38 hospital level care.
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	The manager manages the day-to-day operation of the service. When absent from the facility, the clinical leader would cover and continue to provide all clinical input. The owner/director/GM with support of the administrator/PA would cover the business and non-clinical issues. The owner/director, a director and GM cover the two facilities owned by the organisation and clearly understand the aged care sector. The management team are able to carry out all the required duties under delegated authority. The owner/director (a registered nurse (RN)) with a current annual practising certificate) is also available to support the clinical leader as required. The owner/director interviewed stated that a casual manager is also available to cover the manager if and when required.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an	FA	Administration staff are made aware of the business and quality plans and those interviewed had a good understanding of the processes in place. The quality and risk system in place reflects the principles of continuous improvement. This includes the management of audit activities including regular resident/staff and family satisfaction surveys, monitoring of outcomes and clinical incidents including infection prevention

established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		and control management. The organisation acknowledges the Health and Safety at Work Act 2015 and ensures all requirements are met to adhere to defined safety procedures and practices. Employees are to conduct themselves in a manner that avoids harm to themselves and others. The health and safety committee exists for the purpose of implementing, maintaining and monitoring a safety programme for residents, staff and visitors to the facility. Staff input is encouraged. The manager is the designated health and safety coordinator whose authority and accountability for safety related matters is clearly defined. Hazards are identified and documented. The administrator/PA to the manager described the identification, monitoring and reporting of any risks and the development of mitigation strategies. The risk register is reviewed at least annually. New risks are added to the register following a documented process. The register is current and up to date. There are detailed procedures to show that health and safety is managed to meet the legislative requirements. Terms of reference and meeting minutes reviewed confirmed efficient reporting occurs, action is taken and compared from the previous year and for benchmarking purposes. Regular review and analysis occur, and related information is reported monthly and discussed at the quality and staff meetings. Minutes maintained were available for review. Discussion occurs on pressure injuries (if any), restraints, falls, complaints, adverse events, infections, wounds, audit results and the activities programme. Staff interviewed stated they were involved in quality and risk activities through participating in the internal audits. Relative corrective action sheets are developed and implemented and demonstrated a continuous process of quality improvement is occurring. Annual surveys such as the employee opinion survey, the next of kin and resident survey and the resident satisfaction survey are completed annually. A resident food satisfaction survey was completed 12 March 2021 and was signed off by the manager. The family survey completed 16 January 2020 evidenced that families were satisfied overall with the services provided. Outcomes of surveys and internal audits were compared with the previous year's outcomes and a summary was completed with any recommendations, if they required any action to be taken, by whom and were signed off when completed and dated. Quality improvement was discussed at the staff meeting. Policies and procedures reviewed cover all aspects of the service and contractual requirements and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. A quality consultant is contracted to review and update policies and procedures. Once signed off by the owner/director staff are updated on new policies or changes to policies through the staff meetings, newsletters and memorandums through the electronic pay system.

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse events and near miss events on an accident/incident form. A sample of incident forms reviewed showed these are fully completed, incidents are investigated, action plans developed and actions are followed up in a timely manner. Adverse event data is collated, analysed, and reported to staff at the staff/quality meetings reviewed show discussion in relation to any trends identified, action plans in place and any/or improvements made. An area of improvement was identified in relation to neurological observations not always being completed and/or recorded for those residents who have had an unwitnessed fall (refer to 1.3.3.3). Policy and procedures described essential notification reporting requirements. There have been four Section 31 notices completed in 2019 and four in 2020 to HealthCERT. The manager and clinical leader are fully informed of what agencies to report to when a serious/notifiable event occurs.
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.	FA	Policies and procedures reviewed are in line with good employment practice and relevant legislation and guide human resources management processes. Job descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates where applicable. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained. Checklists are noted on the records reviewed. There is a process for managing the annual practising certificates for all health professionals employed or contracted. Staff orientation includes all necessary components relevant to the role. Employee handbooks are completed and/or care packages (for HCAs) as needed to cover all mandatory education and topics relevant to the individual employee. Staff interviewed reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Most staff interviewed had been at the facility for some years. Staff records reviewed show documentation of completed orientation and a performance review (appraisal) is completed annually. Staff interviewed enjoyed working at the facility and stated that educational opportunities are provided. Continual education is planned on an annual basis. Mandatory training requirements are defined and scheduled to occur over the course of the year. All care and some non-clinical staff have either completed or have commenced a New Zealand Qualifications Authority education programme to meet the requirements of the provider's agreement with the DHB. The manager is responsible for the staff records and was interviewed. Of a total of 44 care staff (Healthcare assistants) seven care staff have completed level four and 13 have completed level three. Three cleaners have completed level 2. Some staff have dual roles. Those currently enrolled include two staff completing level 4 and two staff are completing advanced support level 4. Three staff are completing level 2 NZC Health and Wellbeing and two staff are completing the diversional therapy

		(community facilitation) level 4. In addition to this, the administrator/PA has completed NZC in Business level 3 and the manager is near completion of Level 6 NZC in Business Leadership. Level four HCAs work in the psycho-geriatric service and all have completed relevant training as per the training records reviewed. The education programme also provides topics pertaining to managing younger persons with disabilities (YPDs) and this is also addressed in the YPD residents' recreational plans reviewed. Appraisals were current for all staff. All senior health care assistants and registered nurses have completed and have current first aid certificates. Annual staff competencies were completed and all senior care staff who administer medicines have completed annual medicine competencies which were recorded (refer to 1.3.12).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of the residents. The minimum number of staff is provided during the night shift and consists of two RNs and three HCAs in the hospital/rest home. Two HCAS are employed in the psycho-geriatric (PG) unit on night duty. Good staffing levels are maintained on the morning and afternoon shifts for all areas of service delivery. The PG unit has two HCAs and one DT on both the morning and afternoon shifts. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a six-week roster cycle sampled during the audit confirmed adequate staff cover has been provided. At least one staff member on a shift has a current first aid certificate.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents' records are held both electronically and paper based. Staff have individual passwords to the residents' records data base, such as the medication and record management systems and the interRAI assessment tool. The visiting GP and allied health providers also have access to the system which supports integration of residents' records. Some residents' records are maintained in hard copy. This includes the admission agreement, consent agreements and the current care plan. All hard copies are kept securely in the locked cupboards. Hard copy archived records are stored safely and securely on site. There is an effective system for retrieving both hard copy and electronically stored residents' records. All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift.

Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The entry to service policy includes all the required aspects on the management of enquiries and entry. Anne Maree Garden's admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the residents, family/whānau of choice where appropriate, local communities and referral agencies. Completed Needs Assessment and Service Coordination (NASC) authorisation forms for psychogeriatric, rest home and hospital level of care residents were sighted. Residents in the psychogeriatric unit were admitted with consent from EPOAs and documents sighted verified that EPOAs consented referrals to specialist services. Records sampled confirmed that admission requirements are conducted within the required time frames and signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Relatives and residents interviewed confirmed that they received sufficient information regarding the services to be provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. All required documents such as resuscitation status, recent progress notes, care plan, behavioural monitoring and medication charts are included in the discharge or transfer pack. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident's records to confirm this.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. The e-prescribing electronic system is accessed by use of individual passwords and generic facility log in password. Medications were stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the registered nurses (RNs) when the resident is transferred back to the service from the hospital or any external appointments. Evidence of medication audits and corrective actions completed were sighted. There were no residents self-administering medicines at the time of the audit. Self-administration medication policy and procedure is in place when required. The name of the prescriber, dates of commencement and discontinuation of medicines were documented on the medicine entries sighted. The GP reviewed medicines within the required timeframes. Allergies were clearly indicated, and all residents' photos were current for easy identification. All expired medications were returned to the pharmacy in a timely manner. 8 out of 18 medication charts reviewed had no evidence of evaluation of effectiveness for the administered pro re nata (PRN) medication. The clinical leader had no current medication administration competency in

		place in variance with organisational policy requirements.
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.	FA	There is an approved food plan for the service which expires on 1 September 2021. Meal services are prepared on site and served in the respective dining areas. The menu was reviewed by a dietitian within the past two years. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. The residents' weight was monitored regularly, and supplements provided to residents with identified weight loss issues. Nutritional snacks are available for all residents if needed. The kitchen and pantry were observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges and freezers are maintained. Thermometer calibrations were completed every three months. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The CL reported that all consumers who were declined entry are recorded, and when a prospective resident is declined entry, relatives are informed of the reason for this and made aware of other options or alternative services available. The person is referred to the referral agency to ensure that the resident will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents have their level of care identified through the needs assessment by the NASC agency. The initial assessments were completed within the required time frame on admission while care plans and interRAI were completed within three weeks according to policy. Some of the ongoing reviews completed did not meet time frames that safely met the needs of the residents or ARCC contract requirements (refer criterion 1.3.3.3). Assessments and care plans included input from the residents, family/whānau, and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. Residents and relatives interviewed expressed satisfaction with the assessment process.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans were resident focussed, integrated, and provided continuity of service delivery. The assessed information is used to generate long term care plans and short-term care plans for acute needs. Goals were specific and measurable, and interventions were detailed to address the desired goals/outcomes identified during the assessment process. Behaviour management plans were completed for psychogeriatric residents, triggers were identified with detailed interventions to manage the behaviours of concern. YPD residents had person centred support plans in place and community involvement is encouraged. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, district nurses, physiotherapist, NASC team, dietitian, and GP.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Interventions in the service delivery plans were relevant to address the assessed needs and desired goals/outcomes. All significant changes were reported in a timely manner however post fall assessments and neuro-observations were not completed for the required timeframe as per the policy in place (refer 1.3.3.3). The GP reported that communication was conducted in a transparent manner, medical input was sought in a timely manner that medical orders were followed, and care was person centred. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs, including for YPD residents.
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.	CI	The organisation employs a DT and two other activities coordinators who are currently studying for the DT qualification. Residents' activities information was completed in consultation with the family during the admission process. Activities included celebration of residents' birthdays, van outings, board games, regular walks, music, pet therapy, newspaper reading, national and events of the world. Participation record is completed in the electronic record management system. Residents' meetings were conducted monthly where various issues are discussed. The residents were observed participating in a variety of activities on the days of the audit. There are planned activities and community connections that are suitable for the residents. Regular outings were completed for all residents except under Covid-19 alert levels three and four. Residents and family/whānau interviewed reported overall satisfaction with the level and variety of activities provided.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' long term care plans, interRAI assessments and activity plans were evaluated and updated when there were any changes. However, some interRAI assessments were not completed in a timely manner (refer 1.3.3.3). Relatives, residents, and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans were developed when needed and signed and closed out when the short-term problem has resolved.
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	There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family were kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP. Referrals were made to the mental health team, dietitian, PT, district nurses, podiatry services and palliative care team, respectively.
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	Documented processes for the management of waste and hazardous substances were in place. A contracted service is responsible for collecting waste at timeframes that are pre-arranged which is three times a week. The hazardous substance register was sighted and reviewed and updated last on 21 January 2021. This is signed off by the manager, but the register is maintained by the administrator/PA to the manager. The hazard register covers all chemicals used at this facility, care provision hazards, outside the premises hazards, laundry and cleaning hazards and any kitchen hazards are identified. The doors to the areas storing chemicals were secured and containers labelled. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew how to access information if needed. The maintenance person interviewed ensures the supplies are available for the laundry and the cleaning staff to use. A spills kit is available should an event occur. Any related incidents are reported in a timely manner. There is adequate provision and availability of personal protective clothing and equipment (PPE) and staff were observed using this, including gloves, goggles, masks and gowns as needed. The contracted company representatives are responsible for ensuring adequate stocks of PPE are ordered and available for staff at all times. A cupboard is available with stores of PPE resources for use in the event of an infection pandemic.

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A building warrant of fitness expires 6 July 2021 is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio-medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Improvements have been made to the inside of the facility and to the outside since the previous audit. Rooms are painted as vacated. No major renovations have occurred. Furniture and furnishings are replaced as needed. The psycho-geriatric service is located near the reception area with the lounge being next to the main office. This area is secured and managed in isolation from the other services provided. The unit is self-contained with the individual resident's rooms located in close proximity to the showers and toilet facilities and to the large lounge/dining and activities room. The YPD residents are situated in the rest home and hospital care settings and rooms are individualised to meet the individual younger persons' needs and to meet their interests. External areas are fully maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the designated areas. All efforts are made to ensure the environment is hazard free and that residents are safe at all times. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. Vinyl wall cladding half-way up the walls in the hallways throughout the hospital wing is undergoing replacement due to a water leakage occurring. The vinyl is on order and will be totally replaced as soon as the resources are available.
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	FA	There is a mix of toilet, showers and bathing facilities. There are 35 toilets, eight separate showers and fourteen rooms have their own ensuite bathrooms. There are seven shared rooms that share bathrooms and one couple have their own bathroom/toilet/shower unit of the shared rooms. There are adequate numbers of accessible bathrooms and toilets throughout the facility. All residents' rooms have a hand basin in their room. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence, such as shower chairs and/or hoists if needed. Staff and visitor toilets are available. There is also a shower for staff to use, when pandemic planning is in place. Equipment such as shower chairs and hoists are available as needed.

personal hygiene requirements.		
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	Adequate personal space is provided to allow residents and staff to move around freely within their bedrooms safely. Where rooms are shared, approval would be sought. There are seven shared rooms. The rooms have screening in place to use to maintain privacy at all times. Rooms are personalised with ornaments, photographs and other personal items displayed. There is adequate space to store mobility aides, walking frames, a hoist and wheelchairs. Staff and residents reported adequacy of individual bedrooms. On visual inspection all furniture is provided if residents do not have their own furniture. A variety of beds were sighted, high low, hospital beds mostly. Wardrobes are provided. Safety is maintained as residents' individual rooms are mostly spacious in size.
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	There are communal areas available for residents to engage in activities. The main lounge and dining areas are spacious and enable easy access for residents and staff. A large screen television is available in a separate large lounge available for the activities programme and comfortable seating. Residents are able to access areas for privacy if required as there is two smaller lounge areas available for family/whanau and residents to enjoy. Furniture is appropriate to the setting and residents' needs. It is arranged in a manner which enables residents to mobilise freely. Bookshelves are evident with ex-library books for residents to access anytime in the small lounges. There is a separate dining/lounge area for the PG residents to enjoy. There is a large deck area and a ramp for accessing the upper level or to the gardens at ground level. A lift is available in the new building to access the facilities in this service area. The lounge opens to the deck. The grounds at the front of the facility are well utilised as there is a bus stop in the grounds and adequate seating outside for residents to enjoy the garden.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service	FA	All laundry is undertaken off site. Staff are employed to undertake laundry duties and ensure all laundry is packed in the linen bags in readiness for collection by the contracted service providers as arranged. The staff put away all clean laundry and personal clothing is distributed out to residents daily. The laundry staff in the morning duty remake the beds daily with fresh linen as needed. Trolleys are used for this purpose and this system is working effectively. The laundry person covers seven days a week. Residents/family interviewed reported that laundry is well managed and their clothes are returned in a timely manner. The laundry is set up to meet the needs of the residents. The laundry is divided into dirty and clean areas for infection prevention and control purposes, is well ventilated, clean and tidy in appearance. There are combined

is being provided.		policies and procedures for the laundry and cleaning which meet the infection control standards. There are clear job descriptions for both roles. Each resident has a basket for all clean personal clothes to be placed in before being returned to their individual rooms. There are two cleaners rostered on duty seven days a week. All cleaners have job descriptions. The cleaners' trolley is stored appropriately and safely when not in use. The maintenance person stated that the bottles are refilled as needed and all containers have the labels in place. The product representatives provide education for the domestic staff on a regular basis. Certificates were sighted in the staff records reviewed. Material data sheets are available and accessible as needed. The night care staff have a schedule to follow as do the day staff. The service is maintained to a high standard considering the nature of the services provided.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for all emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 7 June 2003 and remains operative. A trial evacuation takes place six monthly with a copy of the drill sent to the New Zealand Fire Service, the most recent drill being the 4 February 2021. The orientation programme for all newly employed staff includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, torches, batteries and a gas barbecue were sighted and meet the requirement for 72 residents for a minimum of three days. Two water tanks are also available. All supplies are checked monthly. There is a small generator on site for use as a back-up for an oxygenator if in use at the time of a power failure. The manager stated that the service has an agreement with a hire pool company that in the event of an emergency a large generator will be made available for this facility. All emergency supplies are checked regularly with one large bin also being available with all emergency resources needed in an emergency. The maintenance person is responsible for checking the hot water temperature monthly and recording this as required. The thermometer is calibrated annually. Call bells alert staff to residents requiring assistance. The nurse call is connected to the health care assistants' pagers. Call system audits are completed on a regular basis and residents and families reported that staff responded promptly to call bells. The electric gate at the entrance to the facility driveway can be manually operated (such as in a power outage) when needed. The grounds are secured due to the nature of the services provided for safety purposes. Staff ensure the facility is locked at a pre-determined time each evening and care staff do hourly rounds at

		night-time. Outside security lighting is available. Sensor door alarms are in place and close circuit television (CCTV) cameras are activated; however, the service is awaiting a quote to replace the current out-dated system. Signage is available.
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	The residents' individual rooms and communal areas have opening external windows with natural light and safe ventilation. In one large section of the facility underfloor heating is available that is thermostat controlled. Oil heaters are in all other residents' rooms. There are heat pumps located in the main lounge and in the PG unit that are maintained at a comfortable temperature. In the main dining room wall mounted electric heaters are available for the cooler months. Areas visited were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained and heated appropriately.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	PA Low	Anne Maree Gardens provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an appropriate infection prevention and control programme. The CL is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place. Staff are made aware of new infections through daily handovers on each shift, progress notes, and staff meetings. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for residents, staff, and visitors to use. Information and resources to support staff in managing COVID-19 was regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by the MOH were documented. Regular updates and information on Covid-19 is provided to staff, families, and residents. The service managed to isolate and arrange back up staff to cover those who were close contacts of the Covid-19 community transmission not related to the facility. There was norovirus infection outbreak in February 2020 which was managed according to policy. The facility was closed to the public for a week, with GP family/whanau, residents, and relevant authorities notified in a timely manner. Documented evidence of staff and residents affected was sighted. Staff interviewed demonstrated an understanding of the infection prevention and control programme. There was no evidence of the reviewed infection control programme in place on audit day.

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 ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, external infection prevention and control specialist, the medical laboratory, and the attending GP.
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 organisation has documented policies and procedures in place that reflect current best practice. Policies and procedures are accessible and available for staff. These are due for review in June 2021. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. Infection prevention and control orientation guide for new staff and an outbreak information folder were sighted. Staff have received training in hand hygiene, Covid-19 precautions, supra pubic catheter, and norovirus management. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources include GP, laboratories, and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. The ICC reported that an infection control record is completed when a resident has an infection. The infection is recorded in the infection prevention control register and this was verified in documents sighted. A report is presented to the management and staff monthly. Staff interviewed reported that they are informed of infection rates at monthly staff meetings, integrated meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in this facility and demonstrated a sound understanding of the organisation's policies, procedures and practice. The clinical leader is the restraint co-ordinator and has a job description for this role and responsibilities are outlined. On the day of the audit four residents were using restraints and one resident was using an enabler, which are the least restrictive and are used voluntarily at their request. The service has a robust process which ensures the on-going safety and well -being of the resident. Restraint is used as a last resort when all alternatives have been explored. The annual restraint review was recently performed January 2021.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval group made up of the manager, clinical leader, the general practitioner are responsible for the approval of the use of restraints and the restraint processes, as defined in policy. It was evident from review of restraint approval group meeting minutes, review of residents' records and interview with the coordinator that there are clear lines of accountability, that all restraints have been approved and the overall use of restraints is being monitored and analysed. Evidence of family/relative/whanau/ involvement in the decision making (authorisation/consent form), as is required by the organisation's policies and procedures was on record in each case, use of a restraint or an enabler is included in the care planning process and documented in the plan of care.

Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator's involvement and input from the resident's relative/whanau. The restraint coordinator interviewed described the documented process. Families confirmed their involvement. The general practitioner has involvement in the final decision on the safety of the use of the restraint. The assessment process identified the underlying causative factors and/or any history of restraint use (if any), the cultural considerations, alternatives and associated risks identified. The desired outcome was to ensure the residents' safety and security at all times. Completed assessments were sighted in the records of residents who were using a restraint. Currently in use there are three bedrails and one lap belt used for restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Restraint is used safely and in the best interest of the resident. The use of restraint is actively minimised and the restraint coordinator explained how alternative to restraint are discussed with staff and family. The service uses sensor mats and low beds as needed. When restraints are in use frequent monitoring occurs to ensure and to promote safety. The outcome of restraint use is documented. Records of monitoring reviewed had the necessary details and records are maintained electronically by the care staff. Access to advocacy is provided if requested and all processes ensure dignity and privacy is maintained at all times and respected. Restraint is used as a last resort after all other interventions have been considered and de-escalation techniques are used appropriately. The restraint register is maintained and is current and up-to-date. The restraint coordinator is responsible for the register. Staff receive training at commencement of service and training is ongoing. Restraint and de-escalation training was held in 2019, 2020, 2021 including challenging behaviour management. Records of training are documented in the training records and on the individual staff education records of attendance sighted.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' records showed that the individual use of restraints is reviewed and evaluated during the care plan and interRAI assessments undertaken six monthly. The restraint evaluations are also completed by the restraint approval group. Families interviewed confirmed their involvement and satisfaction with the restraint process. The evaluation covers all requirement of the restraint minimisation and safe practice standards including options to eliminate restraint use if possible, with all outcomes being achieved. The staff ensure the restraint policy is followed and all documentation is completed.
Standard 2.2.5: Restraint Monitoring and Quality	FA	The restraint reviews occur six monthly of all restraint use which includes all the requirement of the standard. Six monthly restraint reports are completed, and individual use of restraint use is reported to the quality and staff meetings monthly. Minutes of meetings were reviewed, and this confirmed this includes analysis and

Review Services demonstrate the monitoring and quality review of their use of restraint.		evaluation of the amount and type of restraint considered, the effectiveness of the restraint in use for each resident, the competency of the staff and the appropriateness of the restraint/enabler education provided and feedback from family, the GP, and staff. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes of meetings and interviews with staff and the restraint coordinator confirmed that the use of restraint has been actively reduced over the past year.

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 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	The RN was observed administering medicines following the required medication protocol guidelines and legislative requirements. The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted. Monitoring of medicine fridge and room temperatures is conducted regularly and deviations from normal were reported and attended to promptly. The GP reviews medications every three months. 18 medication charts were sampled, and these were signed when either medication is administered or not administered, refused, and withheld. However, 8 medication charts had no documented evaluations of administered PRN medication these include pain relief, laxatives, and anti-anxiety medicines.	Outcomes of PRN medicines administered were not being consistently documented in all medication charts sampled.	Ensure administered PRN medicine outcomes are documented for effectiveness. 90 days

Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	Annual medication competencies are completed for staff administering medications and medication training records were sighted. However, the clinical leader (CL) had no current medication competency in place and there are assessing, signing off medication competencies for other staff members. This is in variance to the organisational policy requirements.	There was no evidence of current medication competency for the clinical leader, this was last completed in 2017.	Provide evidence of current medication competency for the clinical leader. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	The initial interRAI assessments were completed within three weeks of admission and long-term care plans were reviewed every six months or when there was any change in the condition of a resident. 12 interRAI reassessments reviews were not completed within the required timeframes with overdue interval ranging from six (6) to 67 days. A medical assessment on admission was undertaken in a timely manner and reviewed as a resident`s condition changes, or monthly unless the resident`s condition is documented as stable. In the sampled files two residents who had falls had no post fall assessments completed such as the fall risks assessment. One resident who had a fall sustained a head injury and did not have the required neurological observations completed as per service policy. In addition, one resident who had had an unwitnessed fall had had one set of observations completed and this did not continue as required.	(i)There were 12 overdue interRAI assessments. (ii)Post fall assessments are not being completed when a resident has a fall. (iii) Neurological observations are not always being completed on residents who have had a fall and sustained a head injury or those who have had an unwitnessed fall. The observations are not always taken over the timeframe required as per the adverse event policy and procedure.	(i)Ensure all interRAI assessments are completed within timeframes that safely meet the needs of the residents and ARCC contract requirements. (ii)Ensure a falls assessment is completed after a resident has a fall. (iii) Ensure neurological observations are completed on all residents who sustain a head injury and/or those residents who have had an unwitnessed fall. The observations are to be completed for the required timeframe as per the policy in place. 90 days
Criterion 3.1.3	PA Low	An infection prevention and control policy in	The infection control	Provide evidence of an

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.		place covered aspects of the infection control programme. The infection control programme was appropriate for the management of infection control issues. The evidence for the annual review of the infection control programme was not present on audit day.	programme was not reviewed annually.	annually reviewed infection control programme. 180 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	CI	All complaints both verbal and written are documented on the complaints register. Most complaints reviewed are generated from residents at the monthly residents’ meetings. Any issues of concern to a resident or a group of residents is documented on a complaint form and actioned immediately. These issues/complaints were verified in the residents’ meeting minutes reviewed. The concerns/complaints are discussed at the next staff meeting. The manager signs off all complaints/compliment forms. Memorandums are also used to individual services (e.g., the kitchen if a complaint is about the food service (vegetables being too hard to eat or chew) or compliments to the cooks or the activities staff as well). The date the outcome is communicated to the resident is documented and the complaint form signed off by the manager. The manager records any feedback as part of the complaints process and for ongoing quality improvement purposes. The complaints register records complaints as minor and/or serious. The complaints are reviewed in a timely manner and responded to	Having fully attained the criterion the service can in addition clearly demonstrate that the manager and the administrator who attends the residents’ meetings have collaboratively developed and implemented strategies to improve the complaints management system especially from a residents’ perspective. At all times ensuring any issues or concerns are discussed at the residents’ monthly meetings and actions are commenced immediately. The residents interviewed felt their concerns are listened to and acted on, however small or trivial they may seem. Concerns do not then escalate and/or cause grief, anger or outbursts to staff and/or to other residents. The residents are informed of the Nationwide Health and Disability Advocacy Service with one resident recently following up a concern through this process with assistance of

		and all complaints can be followed through with all action undertaken and outcomes being clearly documented and dated. It does not matter how minor the complaint or issue is for the resident as this is a forum for them to speak out if they are not happy about something concerning them or others. Feedback is also provided to individual residents/family who have complained. Complaint outcomes are discussed at the quality/staff meetings where applicable.	family. Four recommendations made by the advocate following investigation of the complaint were followed through by management and staff to meet the needs of the individual resident and this complaint was effectively closed out without escalating any further and the complainant was satisfied.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The planned activities are meaningful to the residents' needs and abilities. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' files sampled reflect their preferred activities and were evaluated regularly or as when necessary. The DT and the activities coordinators develop a monthly activity planner which covers activities for the rest home, hospital, YPD and psychogeriatric level of care residents. The service initiated a quality improvement project to enable the residents to have a full experience of Christmas and to reminisce with their families thereby providing an opportunity for an interactive community connection. A pilot study was undertaken in 2018 where a Christmas lights show, and activities night was launched at the facility. Residents' families were invited for the launch, there was a lot of interest and enthusiasm for the event. The independent residents assisted staff with preparations for the event with decorations and dropping invitations into the letterboxes of the nearby houses. The displays were later adopted to become an annual event and for the past three years there has been an increased turnout which has attracted other members of the community and surrounding neighbours. This has resulted in the service noticing positive outcomes from these events thus resident feeling loved, connected, happy, reminiscing previous childhood Christmas lights display shows, pampered and having a sense of belonging interacting with members from the community. This has promoted community integration and reduced the stigmatisation for mental health residents at the facility. Positive feedback was	The achievement of the quality improvement projects in the activities programmes and implementation of the programme is rated beyond the expected full attainment. With these projects, there has been a documented review process which includes the analysis and reporting of findings. The introducing of new activities and the evaluation of existing Christmas lights functions include documenting actions to make improvements both in the activities programme and at these annual events. With this there has been increased staff knowledge and confidence and skill in preparing for these events and developing and increasing residents' skills and participation in meaningful activities. The number of attendees, both residents and community, continued to increase each year. Positive outcomes have been measured in staff, resident and relative satisfaction surveys conducted. Pictorial evidence was sighted in the documents provided for review. This was also confirmed in interviews conducted with the staff, residents, GP, and family/whānau, respectively.

		verified from the residents and family surveys conducted. The activities and Christmas lights displays are varied and unique when compared to previous years resulting in record high attendances, stimulating interest, and promoting physical activity thereby reducing boredom in the process.	

End of the report.