

Henrikwest Management Limited - The Beachfront Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Henrikwest Management Limited
Premises audited:	The Beachfront Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 April 2021 End date: 6 April 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:	40

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
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

The Beachfront Home and Hospital provides rest home and hospital level care for up to 55 residents. The service is operated by Henrikwest Management Limited and managed by a group general manager and a facility nurse manager. Residents and families spoke positively about the care provided.

This surveillance 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, staff and contracted allied health providers. A general practitioner was interviewed.

This audit has resulted in two areas identified as requiring improvement in relation to initial interRAI assessments and availability for care staff to access care planning and one in safe and appropriate environment which remains open from the previous audit. Two of the three areas of improvement from the previous audit have been addressed.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreting and translation services if needed.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identification of trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular performance review. Staff levels and skill mix meet the changing needs of residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Policies and procedures provide guidelines for access to service. Residents are assessed prior to entry to the service to confirm their level of care. The nursing team is responsible for assessment, development, and evaluation of care plans. Care plans are developed in consultation with residents and family / whānau.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is an appropriate medicine management system in place. Three monthly medication reviews are conducted by a general practitioner (GP) and these were current. Staff involved in medication administration are assessed as competent to do so.

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. The menu has been reviewed and approved by a dietitian. The service has an 'A grade' food safety rating.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers are currently being used. Eight residents, as documented in the restraint register reviewed, are using a restraint. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific surveillance is undertaken, data is analysed, and results reported and communicated to staff at the staff meetings. Follow-up action is taken 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	15	0	1	1	0	0
Criteria	0	38	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints/compliments policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that eight minor complaints have been received over the last year and the actions taken, through to an agreed resolution, are clearly documented and completed within the timeframes. Action plans showed any required follow-up and improvements have been made where possible. The facility clinical manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to communicate effectively in English. There are communication strategies in place for residents with cognitive</p>

<p>provide an environment conducive to effective communication.</p>		<p>impairment or who have non-verbal means of communication.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business plan reviewed, dated January 2021 to December 2021, clearly outlines the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. The Beachfront Home and Hospital site specific objectives were also clearly documented in the quality improvement plan for 2021 plan sighted. A sample of monthly reports to the senior manager showed adequate information to monitor performance is reported including occupancy, financial performance, emerging risks and issues, quality (clinical) indicators, results of internal audits and variations to expected service delivery.</p> <p>The service is owned by two directors and managed by the group general manager (10 years in this role) who oversees three facilities within the organisation. The business and finance manager has worked for the organisation for seven years. There is an assistant manager who works Monday to Friday at the Beachfront Home and Hospital only. A regional manager covers three services and was present on the day of the audit. The facility clinical manager is an experienced registered nurse who has worked in this role for one year. A clinical lead supports the facility clinical manager.</p> <p>All members of the management team have completed relevant management training for their individual roles. Responsibilities and accountabilities are defined in the job descriptions and individual employment agreements reviewed. The group general manager interviewed confirmed knowledge of the sector, regulatory and reporting requirements.</p> <p>The service holds contracts with the Waitemata District Health Board (WDHB) for age related residential care rest home and hospital level care (hospital level care – LTSCHC and rest home – LTSCHC). On the day of the audit 40 residents were receiving services; 19 rest home care; 20 hospital level care and one resident who is under 65 years of age who is receiving care under the rest home LTSCHC contract. The service can have a maximum of 55 residents. Thirty-two beds are dual purpose.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, regular resident meetings, monitoring of clinical indicators, incidents, including accidents, infections, pressure injuries, falls (with and without injury) staff incidents and health and safety issues.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators. There is monthly reporting to the group general manager and daily reporting regarding any emerging issues. From the monthly reports, graphs and summaries of the facility's data are developed against each of the individual clinical indicators. These reports</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>are discussed at the monthly quality and risk/infection prevention and control/health and safety meetings (Q&R/IPC/H&S), at the registered nurse (RN) meetings, and at the staff meetings. The results in graph form with comparative summaries of the month before were reviewed. Staff interviewed reported their involvement in these different meetings. Regular internal audit activities occur each month against a calendar of audits. The results are discussed at the Q&R/IPC/H&S meetings. Relevant corrective actions are also discussed and were noted in meeting minutes. Meetings with residents are held regularly and they can raise and discuss any concerns or issues they have during these meetings.</p> <p>The organisation`s system of monitoring corrective actions which result from internal audits requires formal reporting through to the group general manager. The facility clinical manager was aware of any areas identified and described the actions taken to address them. The most recent Q&R/IPC/H&S meeting minutes were sighted and recorded discussion of the last internal audit and the actions to be taken. An annual resident satisfaction survey is completed in June each year, as is a staff feedback survey. Last year, positive feedback was received from residents and staff.</p> <p>Policies reviewed cover all necessary aspects of the service delivery and contractual requirements, including reference to the interRAI assessments and other contracts held by this facility. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of any obsolete documents. The general manager is responsible for quality and a quality consultant is contracted to ensure all policies and procedures are up-to-date and current.</p> <p>The group general manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The hazard register reviewed was up to date at the time of the audit. The organisation has policies and procedures which provide guidance on the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the group general manager. A policy and flow chart were available to guide staff. An electronic system has been developed and implemented for any incidents/accidents reported. The information is entered into the electronic system from the hardcopy incident record, then the form is filed in the individual resident`s record by the facility nurse manager. A selection of these reports were sighted for 2020 and 2021. Staff understood their responsibilities for reporting and recording adverse events.</p> <p>The group general manager described essential notification reporting requirements, including for pressure injuries and infection outbreaks. Examples of notifications of significant events made to the Ministry of Health since the previous audit were reviewed mostly related to registered nurse (RN) cover. The facility nurse manager was well</p>

<p>appropriate their family/whānau of choice in an open manner.</p>		<p>informed of statutory and/or regulatory obligations to report. The service's open disclosure policy was sighted.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. New staff members reported, and files reviewed confirmed, that orientation has been completed as required. Staff reported that their orientation prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after three months and then annually thereafter.</p> <p>Continuing education is planned at the facility annually with mandatory training requirements being covered in addition to any site-specific needs. The regional manager interviewed works between three facilities, assists with the development of the annual education plan for staff and is available for advice on any quality management issues. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the Waitemata District Health Board (WDHB). There are two of the five registered nurses (RNs) trained and competent to undertake interRAI assessments.</p> <p>Documentation and records reviewed showed that key competencies (medication, restraint and hand hygiene) have been completed for the majority of staff. All registered nurses and manager have completed first aid training. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). This was an area requiring improvement from the previous audit which has been addressed. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. No bureau staff are contracted at this facility. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage for the hospital level residents.</p>

service providers.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medicine management policies and procedures clearly outline the service provider's responsibilities in relation to all stages of medicine management. 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 service from hospital or any external appointments. Medication competencies were completed annually for all staff administering medication as verified by the lead auditor.</p> <p>There were no residents self-administering medicines at the time of the audit. Self-administration medication policy and procedure is in place when required.</p> <p>The name of the prescriber, dates of commencement and discontinuation of medicines were documented on the medicine charts 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.</p> <p>A health care assistant was observed administering medicines safely, following the required medication protocol guidelines and legislative requirements.</p> <p>The controlled drug register was current and correct. Controlled drugs (CDs) are stored securely. The RNs are the only staff with knowledge of the CDs safe access code. Other medicines, such as pro re nata night sedation, are also checked and documented in the CD register. Weekly and six-monthly stock takes were conducted. Monitoring of medicine fridge is conducted regularly and within the required range. There are no vaccines stored on site. The three GPs review their residents' medications at least every three months.</p> <p>The outcomes of PRN (as required) medicines administered were documented in either the medicine records or progress notes sampled.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service</p>	FA	<p>The food service is provided on site by two cooks who cover the working week. The main meal is provided at lunchtime. There is a four-week summer and winter menu in use dated 2019. Records demonstrate this has been reviewed by a registered dietitian on 6 August 2019. Food supplies are ordered by a designated manager from approved suppliers. The cook advises there is at least a week's food available at all times for use in an emergency.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. There is a template food control plan in use. The Beachfront Home and Hospital has been verified as being compliant with this, by way of an audit of food services by Auckland City Council on 14 January 2020. The service attained 100% in the verification audit and a re-audit is not required for 18 months.</p> <p>Food temperatures, including high risk items are monitored appropriately and recorded. The chef manager interviewed has undertaken relevant food handling training, and records sighted demonstrating other applicable</p>

<p>delivery.</p>		<p>staff have completed food safety training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility by the registered nurse and a nutritional profile is completed. Individual residents' dietary profiles are updated as required and communicated verbally if urgent. The cook confirms having access to this information and a folder containing residents' nutritional profiles were present in the kitchen, and important information also noted on a prominent whiteboard. The personal preferences, any special diets and any modified texture requirements are made known to staff and accommodated in the daily menu plan. One resident's nutritional profile was not current; however, the changes in the resident's dietary needs had been effectively communicated to the cook and was clearly noted on the kitchen whiteboard. Special equipment to meet residents' needs is available.</p> <p>Evidence of food satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Some care plans reviewed sufficiently detailed interventions to address the identified needs of residents. However, there were some exceptions noted where there was insufficient detail or plans were not current or at times not available for care staff (refer criterion 1.3.3.3).</p> <p>Significant changes were reported in a timely manner and prescribed orders carried out. The facility care manager reported that the GP's medical input was sought within an appropriate timeframe, that medical orders were followed, and care was resident centred. This was confirmed by the GP during interview, who confirmed being available on call, that staff contacted the GP appropriately and provided the residents with appropriate and timely care. Care staff confirmed that care was provided as outlined in the care plan and / or communicated verbally.</p> <p>A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	<p>FA</p>	<p>Planned activities are appropriate to the residents' needs and abilities. Activities are normally provided by a diversional therapist (DT) and one activities team coordinator. The management team reported a new diversional therapist has been recruited following the recent resignation of the DT and will commence work the week following audit. The DT normally works Monday to Friday 8.30 to 4.30, and the experienced activities coordinator works Friday and Saturday 9 am to 3.30. The activities coordinator is currently working full time shifts covering the service, until the DT starts.</p> <p>The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. These assessments were completed within two weeks of admission in consultation with the family and residents. A monthly planner is developed, and each resident is given</p>

service.		<p>a copy of the planner. The day's activities were being promoted to remind residents and staff.</p> <p>The activity programme is formulated by the activities staff in consultation with residents and family/whānau. The activities were varied and appropriate for residents receiving rest home and hospital level of care. A daily record of participation / attendance is maintained, and a summary comment noted monthly in the residents' files. There is a formal evaluation of the resident's participation as part of the six-monthly care plan review. The shortfall from the last audit has been addressed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented on a daily basis, or sooner where applicable, by care staff in the progress notes. Changes in residents' ability, health or mood, as noted by the health care assistants, were reported to the nursing team in a timely manner. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals, occurs every six months or sooner if residents' needs change with exceptions noted in criterion 1.3.3.3. These evaluations were carried out by the RNs in conjunction with family, residents, GPs, and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan.</p> <p>Residents' records sampled evidenced that there was monitoring of pain assessments, neurological observations following falls, behaviour monitoring, elimination needs, and evaluation of a range of laboratory tests requested where clinically indicated. Short term care plans and wound care plans were reviewed at least weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whānau were included and informed of all changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building warrant of fitness was displayed at reception and the expiry date was 26 May 2021. No changes have occurred to the facility with exception of some renovation/refurbishment activities to the main entrance, nurses' office and a disability bathroom. Clinical equipment has evidence of current performance monitoring and medical equipment has been recalibrated as needed. All legislative requirements are met.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p>	PA Low	<p>Residents are able to move freely within their individual rooms. Residents who use mobility aids have adequate space for themselves and the care staff to assist them and to maintain independence. Hoists are available at the facility and all staff are trained in their use annually. A wing has designated hospital beds however the lift between two floors has not been yet been changed to enable hospital level residents to be admitted. Management is in the</p>

<p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>progress of discussing this with a lift installation company. This was an area for improvement from the previous audit which remains open.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The facility nurse manager is currently the designated infection prevention and control coordinator (IP&CC) who is responsible for the infection control surveillance and reporting monthly to management and staff on any results. Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract, eye, gastro-intestinal, the upper and lower respiratory tract, skin infections and 'other'. The IP&CC reviews all reported infections, and these were documented. Any new infections and any required management plan are discussed at handover to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of surveillance are shared with staff via the staff meetings and at staff handovers. Graphs are produced that identify any trends by month, and the comparisons against previous months. Follow-up actions required are noted. There have been no outbreaks of infection since the last audit.</p> <p>The GP confirmed staff bring any concerns about a resident with possible infection to the GP in a timely manner.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provides guidance on the safe use of both restraints and enablers. The facility nurse manager interviewed is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation`s policies, procedures and practice and the role and responsibilities involved. On the day of the audit, no residents were using an enabler. Eight restraints were in use. Enablers, when in use, are the least restrictive and used voluntarily at a resident`s request.</p> <p>Restraint is used as a last resort when alternatives have been explored. This was evident on review of the restraint approval minutes, records reviewed, and from interview with staff.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>InterRAI assessments and care plans were completed by the nursing team with input from the diversional therapy (DT), physiotherapist (where applicable), activities coordinator and care staff. This was confirmed by family/whānau and residents in interviews conducted.</p> <p>For one out of six sampled residents the initial interRAI assessment was not undertaken within ARCC contract requirements. For two out of six sampled residents the development of the initial long-term care plan did not align with ARCC contract requirements. The review and updating of a hospital level care resident’s long term care plan (following reassessment at hospital level care) has</p>	<p>Two out of six sampled residents’ files did not have their initial interRAI assessment and / or long-term care plan developed within 21 days of admission as required to meet the ARRC contract. One of these resident’s has subsequently been reassessed as requiring hospital level of care. An updated long term care plan has not yet been developed to reflect the resident’s current care needs in the six weeks since reassessment occurred.</p> <p>A rest home resident had incomplete evaluation of progress towards meeting goals, and strategies for managing ongoing weight loss were not sufficiently detailed in the long-term care plan.</p> <p>Two out of six sampled residents did not have a copy of their current care plan available for care</p>	<p>Ensure initial interRAI assessment and reassessments are conducted within the required contractual timeframes, and the long-term care plans are developed or updated, with sufficient detail related to each resident’s individual needs.</p>

		<p>not occurred in the six weeks since the level of care reassessment was completed.</p> <p>The evaluation of one resident's progress towards achieving their goals was incomplete. Only three out of nine aspects of care had been evaluated by the RN in December 2020. This resident has persistent and ongoing weight loss. While staff can detail the range of interventions undertaken in order to try and address this including having the residents reviewed by the GP, the evaluation of goals has not been completed for this aspect and the ongoing interventions to address weight loss are not sufficiently detailed in the resident's care plan.</p> <p>Ten residents are overdue interRAI reassessments from the previous month.</p> <p>Two out of six residents did not have a copy of their current care plan accessible for staff. Only electronic copies were located during audit. The facility care manager (FCM) advised there have been some challenges with Wi-Fi which may have contributed to difficulties printing. Printed copies were placed in the applicable residents' files during audit.</p>	<p>staff. Only electronic copies were available.</p> <p>Ten residents are overdue interRAI reassessment.</p>	<p>Ensure evaluation of the resident's progress towards achieving their goals is consistently completed.</p> <p>Ensure copies of current care plan documents are readily available for care staff for reference.</p> <p>90 days</p>
<p>Criterion 1.4.4.1</p> <p>Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed</p>	<p>PA Low</p>	<p>Adequate space is provided to allow the resident and staff to move safely around their personal space/bed area. Residents who use mobility aids are able to safely manoeuvre with the assistance of their aid and within their personal space/bed area.</p>	<p>The lift in A wing which is designated for hospital level care residents is currently planned to be upgraded but the work has not yet been completed. The group general manager stated that they are still seeking advice from lift installation companies to work out how this can best be made compliant with the current lift being</p>	<p>To ensure hospital level residents are not admitted into the designated hospital beds in A wing until the</p>

<p>area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.</p>			<p>replaced. There were no hospital level residents in A wing at the time of audit and the staff are aware that this work must be completed prior to the upstairs A wing hospital level care beds being occupied. This was an area identified for improvement from the previous audit which remains open.</p>	<p>current lift is replaced. 180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.