

# Waverley Care Limited - Waverley House

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Waverley Care Limited

**Premises audited:** Waverley House

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 12 May 2021 End date: 13 May 2021

**Proposed changes to current services (if any):** The above organisation is currently in the process of being sold and the tentative settlement date is the 28 June 2021. At the time of audit, no discussion has occurred with the Hawkes Bay District Health Board and the prospective owner/directors are currently waiting on an appointment to be verified with the HBDHB portfolio manager.

**Total beds occupied across all premises included in the audit on the first day of the audit: 20**



# Executive summary of the audit

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## 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.

## General overview of the audit

Waverley House Rest Home provides rest home level care for up to 20 residents. The organisation demonstrates an ongoing commitment to continually review and improve services.

This provisional audit was conducted to assess compliance against all the requirements of the Health and Disability Services Standards and the provider's contract with the district health board (DHB).

The audit included interviews with management, residents, staff, family members and the general practitioner (GP). Policies, procedures, records and documents were reviewed and sampled. Observations were included.

There were four areas identified as requiring improvement. These related to initial interRAI assessments and care planning, neurological investigation/evaluations and the food service in relation to nutritional profiles not being available to kitchen staff and the timeliness of the seasonal menu plans being reviewed.

A routine full certification audit was completed in January 2021. This provisional audit was arranged and undertaken as requested for the prospective buyer.

## **Consumer rights**

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

Open communication between staff, residents and families/whānau is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

## **Organisational management**

The facility is managed by an experienced and suitably qualified manager. A quality and risk management system is in place which includes an annual calendar of audit activity, monitoring of complaints and incidents, health and safety, infection prevention and control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality data is occurring and is reported at the staff meetings, with discussion of any trends. Follow-up occurs where necessary. Meeting minutes are maintained. Adverse events are documented and seen as an opportunity for improvement. Corrective action plans are being

developed and implemented and signed off at time of completion. Informal feedback is sought from residents and families to improve services. Actual and potential risks are identified and mitigated and the hazard register is current.

A suite of policies and procedures cover the necessary areas and are reviewed with input of a quality consultant.

The human resource management policy guides the system for recruitment and appointment of staff. An orientation and staff training programme ensures staff are competent to undertake their role. Ongoing training supports safe service delivery and is recorded. Annual appraisals are performed on all staff.

Staffing levels and skill mix meet the contractual requirements and the changing needs of residents. The registered nurse covers the after-hours and the general practitioner is always available if needed.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## **Continuum of service delivery**

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family/whānau.

The multidisciplinary team, including a registered nurse, and the resident's general practitioner are responsible for assessing and identifying the residents' needs. Care plans are individualised and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. There are effective handover processes in place. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

Food is safely managed. Residents and family/whānau verified satisfaction with meals.

## **Safe and appropriate environment**

The facility has been purpose built. There is single accommodation with three rooms having their own ensuite bathrooms, all of adequate size to provide personal care.

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

Homely communal areas are spacious and maintained at a comfortable temperature. Shaded external areas with seating are available in a central courtyard.

Policies are implemented for the management of waste and hazardous substances. Personal protective equipment and clothing is provided and used by staff. Chemicals and equipment are safely stored. All laundry is undertaken onsite with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to an emergency power source is available. Residents report a timely response to call bells. Staff ensure the facility is safe each night.

## **Restraint minimisation and safe practice**

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no 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 receive training at orientation and annually. Those interviewed demonstrated knowledge and understanding of the restraint and enabler process.

## **Infection prevention and control**

The infection prevention and control programme, led by an experienced and trained infection control coordinator/registered nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	42	0	0	3	0	0
<b>Criteria</b>	0	89	0	2	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Waverley House Rest Home (WHRH) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. This was verified in training records, with the most recent education 20 January 2021. An internal audit was performed on resident's rights on 2 December 2021.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The registered nurse and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form, with the exception of one sampled resident. Staff are liaising with this resident's family and legal</p>

		<p>adviser as the resident is not competent in decision making and the management team advised the enduring power of attorney arrangements in place have been reported to be invalid.</p> <p>Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Competent residents are asked if they want to be resuscitated in the event of emergency, and their decision documented and communicated to staff. The care staff were observed to gain consent for day-to-day care.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were also displayed and available in the facility. Family/whānau members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. One resident has been recently supported by independent advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family/whānau and the community by attending a variety of organised outings including visits to the Returned and Services Association (RSA) monthly, church, and appointments with dental, audiology and optician services where applicable. Linkages also occur as part of the on-site activities programme including weekly communion for applicable residents, entertainment and happy hour.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family/whānau and friends depending on the Covid-19 National Alert Level. At alert level two family/whānau were required to phone for a time to visit the resident, and visitors not allowed at National Alert Level Three and Four except if extenuating circumstances. Waverly House Rest Home has established new electronic communication processes to help residents and family</p>

		members keep connected.
<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 policy and procedures meet the requirements of consumer rights legislation. Residents and family/whānau confirmed access to the complaints procedure. Complaint forms are readily available as are the contact details for advocacy services.</p> <p>The complaints register is maintained by the manager. Two complaints have been received in the last six months and have been effectively closed out. One resident has complained (serial complainant) directly to the health and disability commissioner's (HDC) office on numerous occasions over the last two years and the manager has been in constant contact with HDC. This situation has been managed effectively by both parties. Records were maintained and available. This includes the nature of the complaint, actions taken and outcomes. Complaints records confirm both written and verbal complaints were managed as per legislative requirements. There was also evidence that any concerns shared at resident meetings, or in surveys, were followed up appropriately.</p> <p>Staff interviewed were fully informed about complaints management and knew how to locate the complaint/compliment forms. Compliments were shared with staff at the staff meetings.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family/whānau members interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with the registered nurse (RN) and managers. The Code is displayed in the entry and another area along with information on advocacy services. One resident has been supported by advocacy services.</p> <p>The prospective provider interviewed has a good knowledge of the Health and Disability Consumer Rights (the Code) and the Aged Related Residential Care (ARRC) contract requirements, and how to ensure these are implemented into aged residential care services. In addition to understanding the Code the prospective buyer is fully</p>

		informed about the Nationwide Health and Disability Advocacy Service and how to contact this service for a resident and/or family if required.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families/whānau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room, except a married couple that were admitted to Waverley House Rest Home and one of the key admission considerations was that the couple could share a room which is of appropriate size for two residents to share.</p> <p>Residents are encouraged to maintain their independence by engaging in community activities as part of the activities programme or with family or friends. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, and documented and incorporated into their care plan with one exception (refer to 1.3.3.3). Despite this, the residents' needs were being met as the resident's care needs had been communicated to staff via other processes.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and as part of the ongoing education programme, most recently on 1 February 2020. The family/whānau members interviewed were very satisfied with the care their family member is receiving with feedback on the staffs 'endless patience', 'caring', and 'kind interactions' with residents. Family/whānau members stated they have never observed any interactions between staff and residents that have caused them concern.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability</p>	FA	<p>There is a current Māori health plan. Guidance on tikanga best practice is available. One staff member is reported to identify as Māori.</p>

<p>needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>Two residents who identify as Māori have not identified any individual needs, although are provided with opportunity during the admission and ongoing assessment processes and care plan development and review. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau. The whānau of a Māori resident interviewed reported that staff were respectful in their interactions and met all the resident's needs.</p> <p>Staff are provided with training on the Treaty of Waitangi and the provision of culturally appropriate care as part of the orientation and ongoing education programme. This training last occurred in March 2019,</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed. The exception is noted in 1.3.3.3. Examples included preferred getting up and bedtimes, frequency of showers and the time of the day these were preferred. Residents and family/whānau members confirm they are consulted about their individual needs and preferences and individual needs are being met in a timely manner. Staff confirm they are provided with information by the registered nurse on individual resident spiritual, cultural and other needs as part of the admission and ongoing care plan review process.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family/whānau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p>	<p>FA</p>	<p>The service encourages and promotes good practice by seeking input</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>from external specialist services and allied health professionals, for example, geriatrician and mental health services for older persons as and when required. Staff are provided with regular ongoing education at each staff meeting. Policies and procedures are available to guide staff practice. A new policy related to the Covid-19 vaccination programme is available for staff.</p> <p>The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Other examples of good practice observed included staff working to de-escalate residents with changes in behaviour in a kind and prompt manner. Although the resident audited using tracer methodology care plan did not include sufficient detail on triggers and de-escalation strategies for individual residents' behaviour, staff were familiar with individual residents needs and were working together to provide timely and appropriate care.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members are asked on admission about what events they want to be notified about and the timeframes for any communications. This information is subsequently noted in individual resident care plans. Residents and family/whānau 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 are supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although cannot recall when this has been required due to all residents able to speak English.</p> <p>Staff have been provided with training on open disclosure 20 January 2021.</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>Waverley Aged Care Limited is a 20 bed purpose built facility owned by the manager. The manager has owned this facility for seventeen years (17) and was present for this provisional audit. The manager has an extensive background in the management of health and disability services. The manager is a registered maternity nurse who does not hold an annual practising certificate. The manager is supported by an administration manager with a background in administration and accounts and has extensive knowledge of this service.</p> <p>A current business plan is documented. A mission statement and service philosophy are documented and also displayed in the facility. An updated current organisational chart was sighted. Organisational performance is monitored through inputs, outputs and quality activities appropriate for the size and nature of this rest home service. Management discussions on occupancy, staffing, health and safety, adverse events and business planning occur in an informal manner.</p> <p>Waverley rest home is certified to provide 20 rest home beds. The service holds contracts with the DHB for rest home level care 18 residents on the day of the audit, mental health with two residents and respite level care. No residents were receiving respite care.</p> <p>The pre-determined lead in time when the sale of the facility is completed is planned. A documented Strategic Objectives and Quality Improvement Plan for Waverley House has been prepared. The tentative settlement date has not been confirmed as yet but is proposed for 28 June 2021. The prospective buyer is awaiting an appointment with the DHB at the time of this audit. A strategic plan and operational goals/projects for 2021 – 2022 are clearly outlined. The prospective buyer interviewed stated there are no immediate plans to make changes. Staff have been fully informed one week ago of the prospective sale of the business. Families and residents have also been notified.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service</p>	<p>FA</p>	<p>The manager is supported by a full time administrator and clinically by an experienced registered nurse who also works full time. The registered nurse has worked at this facility since 2014 and is able to</p>

<p>is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>perform the manager's role during a temporary absence. The manager has met the requirements for ongoing management education annually and attends meetings and education provided through the HBDHB. A nurse practitioner is also available from the DHB for additional clinical advice if required.</p> <p>The established transitional plans were reviewed with the prospective buyer and evidenced no immediate changes are planned. The prospective buyers (three directors) will own the facility but one will take on the role of the facility manager/RN. This role is not new as the prospective buyer interviewed has worked in a large aged residential care facility (98 beds) for the last six years in the role of quality manager/RN being responsible for human resource management, quality management and education for all 120 staff. This role was increasing over the last two years</p> <p>The prospective buyer interviewed stated that all staff will be interviewed individually and offered a new individual employment contract. New position descriptions have been developed in readiness for implementation for each designated role.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a documented and implemented basic quality and risk management plan which is compliant to requirements. Ongoing work has continued to ensure that the required policies and procedures are documented and current. A quality consultant is contracted to ensure this occurs in a timely manner. There is a document control policy and procedure.</p> <p>A schedule is maintained of all monitoring and performance requirements. This includes the implementation of routine internal audits. Corrective action plans are developed and implemented and signed off when issues are completed. Quality related data is collated and any trends are identified. Quality data is discussed at the staff meetings held monthly. An education session occurs at all staff meetings and internal audits are discussed. A resident/relative survey was last completed in May 2019 with positive outcomes and a high level of satisfaction overall. Continuous quality improvement is encouraged and promoted at all times.</p>

		<p>A risk management framework and register are documented. Risk management process is discussed in the Waverley House business plan reviewed. Recent health and safety meeting minutes confirmed discussions regarding pandemic planning, emergency planning, environmental assessment and hazard.</p> <p>The prospective buyer interviewed stated that the meeting timeframes already arranged for the year and the educational calendar developed and implemented will not be changed for 2021. Continuity of service provision is being encouraged by management and staff during this transitional time. The prospective facility manger/RN explained that the quality improvement plan will be reviewed at time of takeover as needed in consultation with the other two directors. Planning of activities that will contribute to continuous improvement will continue.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>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.</p>	<p>FA</p>	<p>There is a policy and procedure on adverse events. This includes the reporting, collating, trend analysis and reportable events. The policy references the open disclosure process. All staff have access to incident reporting forms. Clinically related incidents and accidents are forwarded to the registered nurse. Incidents and accidents are monitored by type, time and location. This provides sufficient data to identify trends and develop targeted corrective actions.</p> <p>Incidents/accidents are reported back to staff at the monthly staff meetings as evident in the meeting minutes reviewed. Samples of progress notes confirmed that the required records had been documented and family contacts made. The original incident forms are retained in the individual resident's records. The required first aid measures were undertaken and observations noted (refer to 1.3.8).</p> <p>There has been no Section 31 notices or other incidents/adverse events reported to any external agencies in the last twelve months.</p> <p>At this provisional audit there are currently no legislative or compliance issues that are impacting on the service at the time of the audit. The prospective buyer interviewed is fully informed of the legislative and district health board requirements and obligations in meeting this standard.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are policies and procedures in relation to human resource management which comply with current good employment practice. There is a process for recruitment screening and the validation of professional qualifications. Staff receive an orientation to the facility and to their respective role. The orientation programme includes the essential components of service delivery, including emergency procedures. A buddy programme is implemented and records are maintained. There is health and safety included in the orientation programme and infection prevention and control.</p> <p>Staff records validated the processes were followed and annual staff appraisals are undertaken and the dates recorded.</p> <p>Skills and knowledge for each position are documented in job descriptions reviewed. Job descriptions outline accountability, responsibility and authority. The role of senior caregiver is introduced with four of eight caregivers attaining this level.</p> <p>Staff training policy and procedures includes the required DHB topics. The 2021 staff training plan was sighted. Medication competencies are completed for all senior care givers annually. Eight care givers are employed and all are level three or level four. The registered nurse has completed all relevant training to maintain the annual practising certificate requirements for Nursing Council New Zealand (NCNZ) and to meet the needs of being the sole registered nurse employed at this facility. The registered nurse is trained to complete the interRAI assessments for all residents.</p> <p>The prospective buyer interviewed stated that no changes in employment practice and all legislative requirements will be met. It was verified that current staffing of the facility will not decrease at time of the handover. The full time registered nurse position will roll over but will be reviewed in discussion with the registered nurse (RN) during interview. The facility manager/RN will provide the education programme with support of the registered nurse.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>This is a small facility with a total of 17 staff employed and two management roles. There is a ‘Good Employer Policy’ documented to guide staff. There is currently one full time registered nurse who covers the after-hours seven days a week twenty four hours a day 24/7. The contracted GP provides medical cover after-hours and was available for interview.</p> <p>Current staffing numbers meet contractual requirements. The registered nurse completes all admission interRAI assessments and the six monthly reassessments and updating of the care plans. The number of caregivers rostered per shift is sufficient. A senior care giver is rostered on all shifts. There is always one staff member rostered who has a current first aid certificate.</p> <p>Rosters were sampled to ensure appropriate numbers of staff and adequate cover in the event of a temporary absence. Care staff have the opportunity to swap shifts on the condition they swap with another staff member with similar skills and experience. Amended rosters confirmed sufficient cover is being provided.</p> <p>The manager and the RN have, with discretion, the ability to extend staff hours and staff numbers to respond to difficult situations, circumstances e.g., special events, emergencies, resident acuity issues or any infection outbreaks.</p> <p>The cleaner is responsible for the laundry service and this is covered seven days a week.</p> <p>The two cooks work four days on and four days off on a rotating roster. Kitchen assistants cover the evening shifts. There is one activities assistant five days a week Monday to Friday.</p> <p>The staffing levels reflect the number and mix of residents, resident care levels, lay out of the facility, staff skills and experience.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of</p>

		<p>the person making the entry identifiable. Most resident records including medicine records are paper based. InterRAI records are stored on Momentum.</p> <p>Archived records are held securely on site. The management team is currently going through the records to remove the records of residents who have not received services in the last 10 years. A confidential destruction service is being utilised.</p> <p>No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families/whānau are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process.</p> <p>Family/whānau members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer processes are managed in a planned and co-ordinated manner, with an escort as appropriate. Family members are asked to accompany the resident to booked appointments, and if unable a staff member will be allocated. Details of resident appointments are noted in the diary and communicated to family/whānau and staff.</p> <p>The service uses the DHB's transfer documentation template to facilitate transfer of residents to and from acute care services providing a summary of the residents care needs, and copies of documents including advanced directives, the medication records,</p>

		<p>applicable GP notes and next of kin/EPOA documents. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient transferred to the local acute care facility showed all processes and documentation were completed. Communications with family/whānau are documented in the resident notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of audit. The two caregivers observed demonstrated good knowledge and they had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Pharmacist input is available if required.</p> <p>The RN advised there are no controlled drugs currently on site. Vaccines are not stored on site.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used. A photograph of each resident is attached to their medicine record.</p> <p>At the time of audit, no residents were self-administering medications. Appropriate processes are in place to ensure this is managed in a safe</p>

		<p>manner should this be required.</p> <p>Medication errors are required to be reported via the incident reporting system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>The food service is provided on site by two cooks who share the working week. The menu covers a four-week period, however, has not been reviewed by a qualified dietitian since 2018. Processes are in place to identify individual resident diet needs, however these records (dietary profiles) are not consistently retained either in the kitchen or sampled resident files. The sampled residents are maintaining a stable weight as per the monthly weights documented.</p> <p>All sampled aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan with registration issued by Napier City Council (expiry 30 September 2021). A verification audit occurred on 22 September 2020, with the next verification audit required within 18 months. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family/whānau interviews and satisfaction surveys. Residents are able to present for breakfast at their convenience, 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 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy at the time, the local NASC is advised to ensure the prospective resident and family/whānau are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the</p>

		access agreement related to when a resident's placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, dietary, and continence, as a means to identify any deficits/needs and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the RN, who is the trained interRAI assessor on site. The interRAI assessments have not occurred within ARRC contract timeframes for two residents (refer to 1.3.3.3). Residents and families/whānau confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI and other assessments were reflected in care plans reviewed with the exceptions as noted in the area for improvement raised in 1.3.3.3.</p> <p>Care plans evidence service integration with progress notes written each shift, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families/whānau reported participation in the development of an ongoing review of care plans.</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>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a range of resident's individualised needs was evident in all areas of service provision. The facility GP and a psychiatrist interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a good standard. Care staff confirmed that care was provided as</p>

		<p>outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> <p>Monitoring of residents post a fall is not consistently occurring and this is included in the area for improvement in 1.3.8.1.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by the activities coordinator who has worked in this role for approximately five years, working 12 hours each week over four weekdays.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. This assessment had been completed in four out of five sampled files. One family have yet to provide this information, and work is ongoing to liaise with family as the resident is unable to provide all applicable information. These communications with the resident's family are documented.</p> <p>Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs and participation are evaluated by the activities coordinator and as part of the regular care plan review. The activities programme is issued weekly and recorded on a whiteboard in resident care areas each day.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are invited to participate in activities. Residents and family members interviewed were satisfied with the activities available. Participation is encouraged although is voluntary.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Moderate	<p>Formal care plan evaluations occur every six months in conjunction with the interRAI re-assessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care</p>

		<p>plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, and continence changes. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>Fluid balance charts are not consistently totalled, neurological monitoring post unwitnessed falls is not consistently occurring, and vital signs are being recorded in the narrative of progress notes or on the vital sign chart making it difficult to assess themes over time.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents are able to choose to use another medical practitioner. Two residents retain their own GP. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek appropriate input. Copies of referrals were sighted in residents' files, including to NASC. The DHB gerontology nurse specialist is assisting the RN with scheduled suprapubic catheter changes. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to the emergency department (ED) in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are guidelines on the management of waste and hazardous substances. Personal protective equipment is available throughout the facility. Domestic waste disposal meets the council requirements and is removed from the site weekly. Recycling is encouraged and maintained by staff and cardboard is collected in a skip bin and collected when full as arranged. Infection prevention and control policies include the use of single use items. Chemicals and used products are securely stored or disposed of. Hazardous substances are kept in the laundry. All staff receive training on the use of personal protective equipment (PPE) and the management of waste and</p>

		hazardous substances. Staff were observed using PPE resources correctly during the audit.
<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>There is a current building warrant of fitness displayed at the entrance to the facility with the expiry date of 1 November 2021. Electrical testing is conducted by a contracted provider and is tagged with expiry 11 June 2024. The electrical equipment test report was sighted. Medical equipment was last calibrated January 2021.</p> <p>A routine maintenance schedule is being implemented as required and there is evidence that ongoing maintenance requests are actioned in a timely manner. The maintenance work schedule was sighted. An external service provider is responsible for the lawns and garden. There is a maintenance person available on call.</p> <p>There is a documented health and safety programme. All hazards are identified. These are discussed monthly at the staff meeting. The health and safety programme also includes a process for ensuring contractor safety when on site.</p> <p>The prospective buyer interviewed stated there were no plans at the time of the audit for environmental changes to the service that will need compliance with legal requirements. All building and equipment currently comply with legislative requirements. The facility is well maintained on visual inspection both internally and externally.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are sufficient numbers of toilets, showers and bathing facilities. All are in close proximity to the residents' rooms. There is a combination of shared bathrooms and private ensuite bathrooms (three individual rooms have their own ensuite bathrooms). Hot water is maintained at a consistent and safe temperature which is checked monthly by the manager. Records of temperatures are maintained and any variations are corrected and reported to management. Residents and family members interviewed voiced no concerns regarding the toilet/bathing facilities, including maintaining privacy. There are staff and visitor toilets available.</p>

<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are large in size. Rooms are personalised with resident's own belongings and equipment to meet their individual needs. Safe areas are visible around the bed space for staff to assist residents as needed. Residents' independence is maintained as much as possible.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>All communal areas for entertainment and recreation are large in size to accommodate all twenty residents. There is one large lounge and a small lounge sunroom available. The dining room is located near the kitchen which provides a homely environment. Residents and family members interviewed voiced no concerns regarding the communal and dining areas. There is one large internal courtyard for residents to enjoy with seating and shade being provided.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are cleaning and laundry policies and procedures developed and implemented to guide staff. Cleaning and laundry are undertaken onsite at this rest home. The cleaner is also responsible for the laundry on a daily basis seven days a week. Cleaning and laundry services meet infection control requirements and are of an appropriate standard. The laundry has separation of clean and dirty areas. Staff are trained at orientation in the use of equipment and chemicals. In addition to this further training is provided by a representative from the contracted chemical Company involved with this service. Material data sheets for all products utilised are available. A spills kit is also available if needed. Cleaning and laundry hazards are documented.</p> <p>Cleanliness and laundry standards are monitored through internal audits, resident/family feedback and monthly staff and resident meetings. Residents/family interviewed confirmed the satisfaction of cleaning and laundry services. The facility is observed to be clean on the days of the audit. No hazardous chemicals were accessible. The cleaner's trolley is locked away when not in use. The cleaner interviewed stated and confirmed that there is sufficient time to complete both of these roles on a daily basis.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Appropriate measures are in place to maintain the safety and security of residents over the twenty four hours and during an emergency. The fire service has approved the current evacuation plan 5 December 2000. The last fire evacuation drill was held on 17 September 2020 and another is planned for 25 May 2021 with the fire service in attendance. Attendance records of evacuation drills included the night staff members.</p> <p>A smoke alarm and sprinkler system are in place and fire extinguishers are accessible. An emergency planning meeting was held on the 24 April and minutes of the meeting were sighted. The emergency system includes the pandemic planning with Covid 19 outbreak management. Pandemic planning is current with sufficient supplies PPE, food, equipment and water in the event of an emergency. The building has emergency lighting in the event of a power failure, there is a barbeque (BBQ) available. A generator can be accessed for a longer period of time without power and this is clearly documented in policy reviewed.</p> <p>A nurse call bell system is in place in all bed spaces, bathrooms, toilets and communal areas and these were seen to be within easy reach. A display board was sighted which shows up the room number in the nurses' station when a resident summons assistance.</p> <p>Staff conduct a round of the facility in the evenings to ensure all doors and windows are secure. There is a safety/security code on the front entrance to the facility and the code is displayed (refer to 2.1.1.4). There have been no events related to security.</p> <p>All staff receive training in the management of emergencies which is included in orientation and in-service education. This was confirmed in staff records and interviews.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	<p>FA</p>	<p>The facility has adequate natural light. All rooms have at least one good sized window. There is plenty of natural ventilation and sunlight. Interviews with residents indicate that the internal environment is maintained at a comfortable temperature. There were no concerns</p>

comfortable temperature.		voiced by family/residents interviewed regarding the temperature of the facility.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by an infection control manual. The infection control programme has been reviewed in May 2021.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported to the management team and tabled monthly at the staff meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. On the days of audit, the service was at National Alert Level 1 for Covid-19 and family/whanau visiting was occurring. Visitors were being screened for Covid-19 risks and their temperature was being recorded. The QR code is displayed and visitors are encouraged to scan the QR code as well as record their details in the visitors' book.</p> <p>Influenza vaccinations are offered annually to consenting staff and residents. The Covid-19 vaccination programme is underway. All consenting residents have had their first Covid-19 vaccination, and their second vaccination date is scheduled.</p> <p>Where staff are concerned a resident has developed a respiratory type of illness, the resident is placed in isolation and a Covid-19 test completed. Staff use appropriate personal protective equipment (PPE) while caring for the resident until the symptoms have resolved or the resident is deemed to not be infectious by the GP. Staff are aware they should not come to work if they are unwell.</p> <p>The prospective provider is an experienced ARRC nurse who is familiar with the requirements of this standard and has attended relevant ongoing education on infection prevention and control related</p>

		topics.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for approximately seven years. The coordinator has attended relevant study days and in-services, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection, and these supplies were sighted.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies have been reviewed in the last two years. The policies have been developed by an external consultant. More recently a new policy has been received related to the Covid-19 vaccination programme.</p> <p>A Covid-19 pandemic plan has been developed utilising the DHB preparedness plan template. Information on staff and their 'bubbles' is also recorded.</p> <p>Care delivery, cleaning, 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. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control</p>	FA	<p>Interviews, observation, and documentation verified staff have received education in infection prevention and control at orientation</p>

<p>to all service providers, support staff, and consumers.</p>		<p>and ongoing education sessions. Education is provided by the IPC coordinator/RN. A record of attendance is maintained. Staff have been provided with training on donning and doffing/appropriate use of personal protective equipment and hand hygiene in the last year. The RN advised staff practice this on occasions.</p> <p>Education with residents (and where applicable family) is generally on a one-to-one basis and has included reminders about handwashing, supra pubic catheter care, the influenza and Covid-19 vaccination programme, and advice about remaining in their room if they are unwell. Communication and consent for vaccinations are noted in the resident records.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. 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 the surveillance programme are shared with staff via regular staff meetings and at staff handovers and compared with the prior month. Any actions required are detailed and discussed. A register is maintained in each resident's record of all reported infections and details. There is a low infection rate. The infections detailed in individual resident files had been included in the surveillance data sighted for late 2020 and 2021. There have not been any outbreaks of infection since the last audit.</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>The organisation has implemented policies and procedures last updated 6 May 2021, that support the minimisation of restraint. No restraint or enablers were in use at the time of the audit. An updated register was sighted and staff interviewed understood the difference between restraint and enablers. Restraint is only used as a last resort</p>

		<p>when all other options have been explored. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and thereafter annually. The restraint/enabler policy is reviewed annually.</p> <p>Waverley House provides safe, secure accommodation for the frail, confused and the elderly. A number of residents tend to wander. All personnel involved in the placement of a resident at Waverley House are fully informed and are aware of the environmental restraint which is clearly defined in policy. The keypad and displayed code are explained and demonstrated to all residents' families and friends and any other involved in the resident's care. On admission, consent is obtained from individual residents or next of kin or those with enduring power of attorney. Signed consent forms were evident in the resident records reviewed. Residents that are independent are able to exit the facility whenever they wish. In the event of the fire alarm being activated the locked door automatically releases.</p>
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## 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 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	<p>There is a four-week rotating menu in use. The menu is dated 6 June 2017 and has some handwritten amendments. The menu has not been reviewed by a dietitian since 2018. The cook notes any variations to the food provided (if applicable) each day in a notebook and records resident feedback and comments on the appropriateness of the quantity of food prepared.</p>	<p>The menu has not been reviewed by a registered dietitian to ensure it continues to meet the nutritional needs of residents since 2018.</p>	<p>Ensure the menu is reviewed by a registered dietitian.</p> <p>90 days</p>
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	PA Low	<p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated. The kitchen staff keep the resident's dietary profile in the kitchen until the residents'</p>	<p>Two out of five residents sampled did not have a completed diet profile present in either their clinical record or located in the kitchen.</p>	<p>Ensure individual resident diet profiles are consistently available for all residents and readily available for kitchen staff to refer to.</p>

		<p>individual needs are known to kitchen staff. Two out of five residents sampled did not have a completed diet profile present in either their clinical record or in the kitchen. Despite this, resident and family members were satisfied with the food services provided and confirmed there is more than sufficient quantity of food available.</p> <p>Special equipment, to meet resident's nutritional needs, is available.</p>		90 days
<p>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.</p>	<p>PA Moderate</p>	<p>A general practitioner (GP) completes residents' medical admission within the ARRC contract required time frames with one exception noted. A resident provided with care from their own GP was not seen within five days of admission despite the management team requesting the family that this occurs. The resident's first consultation with the GP occurred 15 days after admission. The GP's have reviewed residents at least three monthly or sooner where clinically indicated.</p> <p>The RN maintains a schedule of when interRAI assessments and long-term care plans are due. All residents have a current InterRAI assessment at audit. However, the resident audited using tracer methodology's initial interRAI assessment and long-term care plan were not completed until 27 days after admission. Another resident's most recent interRAI re-assessment when completed was overdue by 12 days.</p> <p>The care plans sampled were sufficiently detailed to guide care with three exceptions.</p>	<p>One resident's initial interRAI assessment and long-term care plan was not completed until 27 days after admission in variance to ARRC contract requirements. Another resident's interRAI re-assessment was completed 12 days after it was due.</p> <p>The initial care plan of one resident and the long-term care plan for two residents did not include all relevant individualised information to guide care.</p>	<p>Ensure interRAI assessments and re-assessments are consistently conducted and long-term care plans developed and reviewed within ARRC timeframe requirements.</p> <p>Ensure initial and long-term care plans are sufficiently detailed to guide individual resident care.</p> <p>90 days</p>

		<p>The resident audited using tracer methodology did not have sufficient information detailed on triggers for and de-escalation activities for challenging behaviour. Another resident's initial care plan did not note the mobility devices required to be used by the resident. Another resident's care plan did not clearly detail the identified individual spiritual and cultural needs. However, these residents were receiving appropriate care as the resident's care needs had been effectively communicated via other methods.</p> <p>Evidence of documented medical records and correspondence, such as referral letters from other allied health professionals, were sighted in files sampled. Sampled medicine records had been reviewed in the last three months by the GP.</p> <p>Progress notes are completed every shift and more often if there are any changes in residents' conditions. A multidisciplinary approach is adopted to promote continuity in service delivery, and this includes the GP, management team, registered nurse, caregivers, activities coordinator, residents, and their family/whānau.</p>		
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and</p>	<p>PA</p> <p>Moderate</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN as verified by care staff and the RN interviewed.</p> <p>Formal care plan evaluations occur in conjunction with the interRAI re-assessment, or as residents' needs change.</p>	<p>Neurological observations are not consistency occurring of residents following unwitnessed falls.</p> <p>Fluid balance charts are infrequently totalled.</p> <p>There is variation in where vital</p>	<p>Ensure the organisations requirements for neurological observation of residents post applicable falls are clearly communicated and implemented.</p>

<p>progress towards meeting the desired outcome.</p>		<p>Neurological monitoring was undertaken following some of the residents' unwitnessed falls however the frequency and duration is not consistent in the applicable files sighted. For one resident, staff documented that the resident did not hit their head during the fall, however the resident is not competent in decision making and neurological monitoring should have occurred as the resident was taking anticoagulants. There was variation in the frequency and duration of neurological monitoring for the other two applicable residents. The neurological monitoring form notes requirements for monitoring, which was different to the information displayed on the office wall. There was variation in the understanding of required processes between the RN and two caregivers interviewed on this topic.</p> <p>Two residents had fluid balance charts in use. These were being completed; however, were infrequently totalled.</p> <p>Pain assessments are being conducted prior to and following pro re nata pain medication administration with infrequent exception. Bowel charts are maintained for applicable residents.</p> <p>One resident has a short-term care plan requested daily monitoring of blood pressure in the morning before the resident rises each day. Monitoring is occurring, although the results are being documented in the narrative of the progress notes by some staff and on the vital sign chart by others, making it difficult to easily review the results and trends over time.</p>	<p>signs are recorded for the resident requiring daily monitoring making it difficult to assess results and trends over time.</p>	<p>Total fluid balance charts daily.</p> <p>Ensure vital signs are recorded in a format that enables monitoring of themes and trends over time.</p> <p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.