

Metlifecare Limited - Metlifecare Somervale

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:	Metlifecare Limited
Premises audited:	Metlifecare Somervale
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 May 2021 End date: 12 May 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:	68

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Metlifecare Somervale provides rest home and hospital level care for up to 69 residents. The service is operated by Metlifecare Limited and managed by a nurse manager who reports to the village manager. The only changes since the previous audit have been the appointment of a new nurse manager 14 months ago and a new village manager eight weeks ago.

This unannounced 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 files, observations and interviews with residents, family, management, staff including the regional clinical manager and telephone interview with a general practitioner.

Residents and families spoke positively about the care provided.

This audit identified four areas for improvement. These relate to overdue interRAI assessments, updating care plans following a change in a resident's condition, expired medicines and food temperature control monitoring. A previous rating of continuous improvement in quality and risk management is ongoing.

The Ministry of Health requested feedback on the implementation of recommendations made by the Office of the Health and Disability Commissioner following a 2017 complaint. Appropriate and effective actions have been implemented to address these areas and are described throughout this report.

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.

Implemented systems and the environment is conducive to effective communication. The complaints management system meets the requirements of the Code and is known by staff, residents and their families. Residents and family members interviewed reported that the manager immediately responds to and addresses any concerns they raise.

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.

The organisations five year strategic plan and annual business and quality risk management plans include values and a mission statement, the direction and scope of services plus annual quality indicators and goals for Somervale Care home.

Experienced and suitably qualified people manage the services being delivered.

The quality and risk management system includes monitoring all areas of service delivery and benchmarking quality data. Quality improvement data is collected, analysed for 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.

The appointment, orientation and management of staff is based on good employment practices. A systematic approach to identify and deliver ongoing training, supports safe service delivery and includes regular individual performance review.

Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The entry to service pathway is clearly outlined in the policies and procedures sighted. Needs Assessment Service Coordination (NASC) team assess residents prior to entry to confirm their level of care. Assessments and care plans are completed and evaluated by the registered nurses (RNs) at the service. Short term care plans are developed for acute problems, these were evaluated and closed out in a timely manner.

Activities plans are completed by the diversional therapist (DT) and an activities coordinator (AC) five days a week while weekends are for family visits and church services. Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whānau expressed satisfaction with the activities programme in place.

There is a medication management policy in place. The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent. Three monthly reviews are completed by the general practitioner (GP) and nurse practitioner (NP).

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There have been no changes to the structure of the buildings since the previous audit. A current building warrant of fitness is on display.

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 policies and procedures that support the minimisation of restraint. At the time of audit, the facility was restraint and enabler free. There is a comprehensive assessment, approval and monitoring process identified in policy should restraint be required. Policy states that the 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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	2	2	0	0
Criteria	0	39	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Feedback forms used for making complaints or identifying concerns are located throughout the facility.</p> <p>The complaints register reviewed showed 17 complaints had been received since the new manager took up the role in 2019. Two of these received in the weeks before audit were still open and all others had an auditable record that showed actions taken, through to an agreed resolution had been completed within acceptable timeframes. All complaints are registered electronically. Those sampled contained extensive notes about investigations, communications between parties and where required the actions taken for improvements. The nurse manager is responsible for complaints management and follow up. The regional clinical manager and upward management reports are kept advised of the progress on all complaints. Findings from complaints are discussed at the quality and risk forums. All staff interviewed confirmed a sound understanding of the complaints process and what actions are required. There was evidence that each of the recommendations made from the Health and Disability Commissioners office following a complaint investigation into the standard of care had been implemented prior to release of the report findings.</p>
Standard 1.1.9:	FA	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

Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		<p>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. The new nurse manager has implemented various new methods for enhancing communication for families and between staff and external health providers. Examples of this are the 'checklist for transfer of care ' for discharge from public hospital to be completed by the receiving RN. An easy to understand information sheet for families about death and the dying process is provided appropriately. A comprehensive palliative care resource folder for RNs and all care has also been compiled that contains the Te Ara Whakapiri toolkit and other guidelines specific to the expected standards of care at Somervale.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. Staff are also able to provide interpretation as and when needed and family members are available.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of quarterly reviews against the business plan and monthly data reports which go to the board of directors showed adequate information to monitor performance is reported including occupancy, resident information, financial performance, emerging risks and issues.</p> <p>The service is managed by a nurse manager (NM) who is a registered nurse with current annual practicing certificate and other relevant qualifications. This person took up the role 14 months ago and has a background in health. A senior registered nurse oversees all resident care. Both are supported by a regional clinical manager, who was on site for this audit. Responsibilities and accountabilities are defined in their job descriptions and employment agreements. The NM reports directly to the village manager who was appointed eight weeks ago.</p> <p>The NM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at Metlifecare conferences and study days and Age Care Association conferences.</p> <p>Somervale Care home holds contracts with the Bay of Plenty District Health Board (BOPDHB) for respite, complex medical conditions, palliative care, transitional acute care, rest home and short term rehabilitation.</p> <p>Sixty-eight residents were receiving services under the Age Related Residential Care contract (16 rest home and 52 hospital level care). Two hospital residents were receiving services under the Transitional Acute Care Services (TACS) contract, and one hospital level care resident was on respite.</p>
Standard 1.2.2: Service Management The organisation	FA	Click here to enter text

ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<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, audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls, wounds and pressure injuries. Quality data is benchmarked against other Metlifecare sites and against previously collected data. The organisation is still benchmarking Metlifecare sites against five other New Zealand age care providers. Infection control data is benchmarked by a contracted off-site provider.</p> <p>Somervale Care home has initiated a number of quality improvements to augment communication and care processes. There are other larger quality improvement projects being rolled out in the area. The previous rating of continuous improvement in 1.2.3.6 is ongoing.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the organisational clinical governance meetings, quality and risk team meetings, clinical management team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through being members of specific committees such as health and safety, audit activities and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey results (August 2020) showed Somervale had gained improvements from the previous two years results in meals/dining experiences up to 95%. Ratings for the care team and activities were 100%.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. 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 obsolete documents. Policies and procedures are organisational wide and managed at head office. The policies are relevant and reflected good practice related to medical (non-acute) care.</p> <p>The NM described the processes for the identification, monitoring, review and reporting of risks and development of</p>

		mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The health and safety committee review all hazards and the hazard register was up to date.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. This information is then recorded electronically. A sample of incidents reviewed showed all actions fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported across all levels of the organisation. Recorded incidents are sent to the nurse manager daily for review of all incidents and accidents that occur. The service uses the data from incidents and accidents, including service shortfalls to make improvements where possible.</p> <p>The NM described essential notification reporting requirements, including for pressure injuries. They advised there has been two notifications made to the Ministry of Health, and the DHB using section 31 reporting since the previous audit. One in September 2020 related to a resident's motor vehicle accident and a resident's friction pressure injury in April 2021. There have been no police investigations, coroner's inquests, issues based audits or public health notifications made since the previous audit.</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>	FA	<p>Staff 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 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. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period and thereafter an annual appraisal is completed. Staff training and education is relevant to medical (non-acute) care.</p> <p>Continuing education is planned on an annual basis. Mandatory training requirements are presented six monthly and staff attendance is monitored to ensure all staff complete the training annually. 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 DHB. Of the 44 care givers employed (11 are casually employed) 27 have completed level 4 of the National Certificate in Health and Wellness, four are at level 3, four are at level 2 and one is at level 1. Eight staff have either not started the qualification or are already long term experienced carers. Three of the 15 RNs are trained and maintaining their annual competency requirements to undertake interRAI assessments. One more RN has completed the training and concluding competency testing to achieve this.</p>

		<p>Records reviewed demonstrated completion of the required interRAI training and completion of annual performance appraisals.</p> <p>Each of the 15 RN's have current first aid certificates, and have passed competency testing in the use of syringe drivers used for pain management with palliative care residents. There was documented evidence that all RNs and a number of care staff have also completed training in Te Ara Whakapiri (Ministry of Health guidelines for care in the last days of life).</p> <p>The staff interviewed expressed confidence in their ability to effectively identify, attend to and manage care for people who are dying and their family members. There had been 10 deaths in the facility in the month preceding this audit, and all had been managed without incident.</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>	FA	<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). 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 there were adequate staff available to complete the work allocated to them. Ten carers and three RNs are rostered on each morning and afternoon shift, plus the senior RN and nurse manager on site Monday to Friday. Two RNs and three carer's area allocated each night shift. Rosters clearly showed that staffing levels were increased to meet the interRAI acuity level report findings. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All RNs are maintaining current first aid certificates so there is always at least one staff member on duty with this.</p> <p>The NM works five days per week, two activities staff work 80 hours per week and reception staff 40 hours per week. There is 100 hours of dedicated laundry and cleaning staff each week. Maintenance staff (shared with the village) are available five days per week and on-call, and there are sufficient staff allocated to provide food services. Since the previous audit care staff have been relieved of some tasks by an external contract that provides staff to clean up after every meal service in each of the dining areas/ or 'pods'. Each pod has a kitchen, dining area and lounge for around 12 residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p>	PA Moderate	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Indications for use are noted for 'as required' medications, allergies are clearly indicated, and photos were current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. The medication and associated documentation are in place.</p>

and timely manner that complies with current legislative requirements and safe practice guidelines.		<p>Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from hospital or any external appointments. The RNs check medicines against the prescription, and these were noted in the medication electronic management system.</p> <p>There is a process for returning unwanted medicines to the pharmacy in a timely manner. Medications were stored in a safe and secure way in the trollies and locked storerooms. Medication competencies were completed annually for all staff administering medication. The senior registered nurse reported that some medication related audits were conducted.</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. Outcomes of pro re nata (PRN) were documented in the electronic management system. Residents who had swallowing issues had appropriate assessments and safe processes to manage associated risks.</p> <p>An improvement is required to the management of pro re nata (PRN) medication.</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>	PA Moderate	<p>The food service is run by the kitchen manager and assisted by the cooks and kitchen hands. The kitchen service complies with current food safety legislation and guidelines. There is an approved food control plan for the service which expires 26 July 2021. Meal services are prepared on site and served in the respective dining areas. The menu was reviewed by the registered dietitian in April 2021. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents' weight was monitored regularly, and supplements provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. The residents and family/whānau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p> <p>An improvement is required to ensure food temperature monitoring is occurring and records are maintained.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and</p>	PA Low	<p>InterRAI assessments were completed however these were not consistently reviewed within the required timeframes. Assessments and care plans included input from the family/whānau, residents, and other health team members as appropriate. Additional assessments were completed according to required needs (e.g., behavioural, cognition, wound, nutritional, continence, skin and falls, pressure risk assessments). The RNs utilises standardised risk assessment tools on admission and when required uses the identification, situation, background, assessment, and recommendation tool (ISBAR) reporting changes in residents' status. All this is reported to the GP or NP and</p>

preferences are gathered and recorded in a timely manner.		<p>management team in a timely manner. The NP confirmed in interview conducted that comprehensive assessments of residents were completed by the medical and nursing team and further recommendations initiated. The senior registered nurse also reiterated that RNs either text, phone or email the GP or NP for further guidance if they have concerns with management of certain conditions. Further referrals suggested were followed up. Evidence of assessments and evaluations completed were sighted in files reviewed.</p> <p>The physiotherapist visits the service twice a week, completes assessments and evaluations on admission, ongoing monitoring of residents' mobility issues, and conducting post fall assessments, respectively. There are policies and procedures in place to manage residents with the following conditions cerebrovascular accidents, swallowing difficulties, agitation, and behavioural issues. Staff were further trained to manage residents needing end of life care and in the use of anticipatory medicines for comfort. Evidence of documented assessments of residents presenting with various issues such as swallowing difficulties, impaired mobility and behavioural issues of concerns and outcomes identified were sighted. Regular reviews were conducted and specialist help sought in a timely manner. Wound specialist, speech language therapist, dietitians and mental health team were consulted to assess residents requiring their input. In interviews conducted, family/whānau and residents expressed satisfaction with 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>	PA Low	<p>Short term care plans were used for short-term needs. Behaviour management plans were implemented as required for some resident either assessed as rest home or hospital level of care with behavioural issues. Family/whānau and residents confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapist, speech language therapist, district nurses, dietitian, NP, and GP.</p> <p>An improvement is required to ensure residents' care plans reflect all assessed needs.</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>Care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Outcomes from interRAI assessments were not consistently documented (Refer 1.3.5.2). Significant changes were reported to the GP or NP in a timely manner and prescribed orders carried out. Relevant interventions were documented for residents with behavioural issues, impaired skin integrity and swallowing difficulties. The senior registered nurse reported that the GP and NP medical input were sought within appropriate timeframes, that medical orders were followed, and care was resident centred. This was confirmed by the NP during interview conducted. Care staff confirmed that care was provided as outlined in the care plans. A range of equipment and resources are available, suited to the levels of care provided and in accordance with the residents' needs. RNs have received appropriate training and passed competency testing in the use of syringe drivers used for pain management with palliative care residents. Food and fluid charts are initiated as required.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The planned activities are meaningful to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' files sampled reflect their preferred activities and were evaluated regularly or as when necessary. The DT and activities coordinator develop a monthly activity planner which covers activities for the rest home and hospital level of care residents. These were posted on the notice boards to remind residents of upcoming activities.</p> <p>Residents' activities information was completed in consultation with the family during the admission process. Activities included group, individual, celebration of residents' birthdays, van outings, board games, indoor bowls, pampering and hairdressing, regular walks, music, newspaper reading, national and events of the world. Residents' meetings are conducted monthly where various issues are discussed.</p> <p>The residents were observed participating in a variety of activities on the day of the audit. There are planned activities and community connections that are suitable for the residents. Regular outings were completed for residents interested in going out except under COVID-19 alert level three and four. Residents and family/whānau interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' long term care plans, interRAI assessments and activity plans were evaluated at least six monthly and updated when there were any changes (Refer 1.3.4.2 and 1.3.5.2). Resident care plans were individualised. Relatives, residents, and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Resident records sampled evidenced that there were monitoring of; fluid balance charts (intake and output), pain assessment, neurological observations post falls, and evaluation of a range of requested laboratory tests where clinically indicated. Short term care plans were developed when needed, signed, and closed out when the short-term problem has resolved.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	FA	<p>There had been no changes to the buildings since the previous audit in 2019. A current building warrant of fitness (expiry date 20 September 2021) is publicly displayed.</p>

for their purpose.		
<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>	FA	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. The data is entered into the infection register. Monthly reports are completed and sent to the nurse manager and then regional clinical manager and clinical director for benchmarking. The regional clinical manager reported that an infection control record is completed when a resident has an infection. Benchmarking of infection is completed against other sister facilities through an external infection control specialist service. Staff interviewed reported that they are informed of infection rates at handovers, monthly staff meetings and through compiled reports. The GP and NP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, respectively.</p> <p>Information and resources to support staff in managing COVID-19 was regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by the MOH were documented. There was no infection outbreak reported 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>	FA	<p>On the day of audit, no residents were using restraints or enablers. The facility is succeeding in maintaining a restraint free environment.</p> <p>In the event that a restraint or enablers is required, the set of policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both. The nurse manager who is the restraint coordinator provides support and oversight for enabler and restraint management. This person demonstrated a sound understanding of their role and responsibilities and the organisation's policies and procedures. The restraint coordinator confirmed that restraint would only be used as a last resort when all alternatives have been explored.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	<p>The RN and the nursing student were observed administering medicines following the required medication protocol guidelines and legislative requirements. The controlled drug register was current and correct. Recommended controlled drug stock takes were conducted. Monitoring of medicine fridge and room temperatures is conducted regularly and deviations from normal were reported and attended to promptly. The GP and NP complete three-monthly medication reviews.</p> <p>There were expired PRN medicines in the medication trollies and medication rooms.</p>	Eleven rolls of PRN medications held in stock had expired.	<p>Ensure the medication management system meet the requirements of the standard.</p> <p>60 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement,</p>	PA Moderate	Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of fridges and freezers are maintained,	Food temperature monitoring and	Ensure food temperature monitoring

production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		however, food serving temperatures were not being monitored as per the food control plan requirements.	recording is not occurring as required by legislation.	and recording is conducted. 30 days
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	Residents have their level of care identified through the needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' care plans and interRAI are completed within three weeks, according to policy. InterRAI assessments were not completed within the aged related residential care contract (ARRC) required timeframes. The organisation had processes in place to manage completion of all overdue assessments.	Eleven resident interRAI assessments were not completed within ARRC required timeframes the overdue intervals ranges from 15 to 83 days.	<p>Complete interRAI assessments within the required time frames.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	The assessment findings and input from resident and/or family/whānau informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised, however residents care plans have not been updated to include a change in the resident's condition for example, pressure injuries.	Two residents' care plans reviewed did not have documentation of interRAI triggered outcomes.	<p>Provide evidence that outcomes from interRAI assessments are consistently included in the residents' care plans.</p> <p>60 days</p>

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.