

Annie Brydon Complex Limited - Te Mahana Resthome

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Annie Brydon Complex Limited

Premises audited: Te Mahana Resthome

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 14 July 2021 End date: 15 July 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: 21

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Te Mahana Resthome provides rest home level care for up to 22 residents. The service is operated by Te Mahana Limited and is managed by a facility manager.

Residents and a families stated they were very satisfied with the level of care provided.

This certification audit was undertaken to establish compliance with the Health and Disability Service Standards and the service's contract with the District Health Board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, the manager, staff, current directors, new directors and a general practitioner.

Areas requiring improvement from this audit relate to the analysis and reporting of clinical indicators, aspects of care planning including sufficient information documented relating to planning and evaluation, and the activities programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their family/whānau 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. The services provided support personal privacy, independence, individuality, and dignity. Staff interact with residents in a respectful manner.

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

There is a Māori health plan to guide staff to ensure that residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect, or discrimination.

The service encourages residents to maintain linkages with a range of specialist health care providers, and the community to meet residents' needs.

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no complaint investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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A business plan including a mission statement, expectations and strategic direction and quality and risk management systems are fully implemented at Te Mahana Resthome. Systems are in place for monitoring the service, including regular reporting by the facility manager to the directors.

The facility is managed by a facility manager who is a registered nurse and who started in July 2020. The manager is supported by the directors and the health professionals from the medical centre situated close to the facility.

There is an internal audit programme. Adverse events are documented on incident/accident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address any areas that require improvement including audits, satisfaction surveys and incident/accidents. Staff/quality and residents' meetings are held on a regular basis. Actual and potential risks including health and safety risks are identified and mitigated.

Policies and procedures on human resources management are in place. Human resources processes are followed. Staff have the required qualifications. An in-service education programme is provided, and staff performance is monitored. A documented rationale for determining staffing levels and skill mix is in place.

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

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The admission process is efficiently managed by the facility manager/registered nurse, with relevant information provided to the potential resident/family. The registered nurse and general practitioner assess residents' needs within an appropriate time frame following admission. Care plans are developed. Routine care plan evaluations are completed in a timely manner. Residents are referred or transferred to other health services as required.

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

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

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals. There is a current food control plan in place.

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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A current building warrant of fitness is displayed at the front entrance. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents' bedrooms provide single accommodation. Lounges, dining areas and alcoves are available. External areas for sitting and shading are provided. An appropriate call bell system is available, and security and emergency systems are in place.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site. Cleaning and laundry systems are audited for effectiveness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using restraints and enablers at the time of audit. One resident up until a day prior to the audit had been using a restraint and was being trialled without one on the days of audit.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme is facilitated by the facility manager/registered nurse, and is aimed 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 and competencies.

Aged care specific infection surveillance is undertaken and results summarised monthly. Follow-up action is taken as and when required. There have been no infection outbreaks since the last audit.

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	46	0	2	2	0	0
Criteria	0	97	0	1	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Te Mahana Resthome has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The interviewed staff understood the requirements of the Code and were observed communicating with residents in a respectful manner. The residents confirmed that options are provided, dignity and privacy is maintained during care provision, and they are encouraged to maintain their independence. Training on the Code is included as part of the orientation process for all staff employed and in ongoing mandatory training, as was verified in training records sighted.</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 facility manager 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 as part of the organisation's admission agreement and consent form and includes general treatment and care, transport, the resident's name being written on the board, photography for monitoring wounds, and having the resident's photograph on the medicine chart. Residents are advised there is no smoking on site and that they are not allowed to have portable electronic heaters in their room (fire safety) as part of the consent process.</p> <p>Advance care planning is encouraged, and these were sighted in residents' files where applicable. Resuscitation treatment plans were completed in the residents' files reviewed, and processes were in</p>

		<p>place to communicate each resident's wishes.</p> <p>Influenza and Covid-19 vaccination consents were obtained for residents who have received the influenza vaccinations and will receive the Covid-19 vaccination. Documentation in relation to enduring power of attorney (EPOA) and processes for residents unable to consent is defined and documented, as relevant. EPOA documentation was sighted in residents' files reviewed. The general practitioner and facility manager liaised with the family of one resident where there were concerns about the resident's competency in decision making. After formal cognition assessments were completed by the GP, processes were subsequently implemented to establish a welfare guardian. A welfare guardian has since been appointed, and Te Mahana Resthome is waiting for the confirmation to be provided for the resident's records.</p> <p>Staff were observed to gain consent for daily care. The interviewed residents and family/whānau confirmed being consulted and provided with information in relation to treatment plans.</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>	FA	<p>Residents are given a copy of the Code, which also includes information on the Advocacy Service during the admission process. Information on Advocacy services is included in the admission agreement. Posters and brochures related to the Advocacy Service were also displayed at the reception area. Family/whānau and residents spoken with were aware of the Advocacy Service. There is a Te Mahana Resthome advocate who normally visits at least monthly and sooner where required. The advocate chairs the monthly residents' meetings. The facility manager/registered nurse provided examples of the involvement of support people in relation to provision of care and care planning. Staff have received training on 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>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment. This was confirmed by the interviewed residents. A variety of visitors were observed visiting residents during the days of the audit. Staff note any appointments in the communication book and examples sighted included residents going on family outings, to the optometrist, or appointments with the GP or other specialist health professionals.</p> <p>The facility normally has unrestricted visiting hours (except as required to comply with the national Covid-19 alert level) and encourages visits from residents' family/whānau and friends. Family/whānau interviewed stated they always felt welcome when they visited regardless of the time.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is additional complaints information available. No complaints have been received since the previous audit. The register meets the requirements of Right 10 of the Code.</p> <p>The facility manager (FM) is responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Residents and families confirmed they knew how to make a complaint and who they would go to if needed.</p> <p>There have been no complaint investigations by external agencies since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided. Advocacy service information is included in the admission agreement and is discussed with the residents and family/whānau on admission. Family/whānau of choice, where appropriate, or residents' legal representatives are involved during the admission process and explanation on the Code is provided to them when required. This was confirmed in family/whānau interviews conducted. The Code pamphlets were displayed at the reception area together with information on advocacy services, how to make a complaint and other information brochures on aged related residential care.</p>
<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>	<p>FA</p>	<p>Residents and family/whānau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Staff were observed to maintain privacy throughout the audit. Residents confirmed that their personal belongings are safe, and they receive their laundry back in a timely manner after laundering.</p> <p>Residents are encouraged and supported to attend to community activities and to participate in activities of their own choice. The nursing assessments identify resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified. Residents and family confirm they are satisfied their individual needs are being met by staff in a timely manner, although some residents' care plans are not sufficiently detailed (refer to 1.3.5.2).</p> <p>Interviewed staff understood the service's policy on abuse and neglect, including what to do should there be any signs. The facility manager/registered nurse advised there have not been any reported concerns. Residents and family/whānau interviewed also confirmed they had no concerns about how staff treated them, their family member or other residents. Education on abuse and neglect was</p>

		confirmed to occur during orientation and as part of the ongoing education programme.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Residents' cultural values and beliefs are assessed on admission as part of the admission process. One resident identifies as Māori and their care plan noted staff should refer to the Te Whare Tapa Wha care plan. This document could not be located in the resident's records (refer to 1.3.5.2). Despite this, the resident was happy with the care provided.</p> <p>The principles of the Treaty of Waitangi are incorporated into daily practice, as is the importance of whānau. There is a current Māori health plan. A local kaumatua visits the rest home most weeks. The kaumatua had a family member in Te Mahana and has kept in contact with staff and residents and offers advice and 'aroha'/support. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. There are two staff who identify as Māori.</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>	FA	<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 exceptions are noted in criterion 1.3.5.2.</p> <p>There are regular church services held on site and participation is voluntary. Residents who wish to go to gatherings/functions outside the facility were supported. Staff note these details in the communication book to ensure the resident is ready by the agreed pick-up time. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family/whānau interviewed stated that residents were treated fairly with no discrimination, harassment or exploitation and they felt safe. The orientation process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. There are policies and procedures to guide staff on processes to follow should they suspect any form of exploitation. The staff demonstrated a clear understanding of the process. Staff are required to sign a confidentiality agreement, code of conduct/house rules on employment and copies of these documents were present in sampled staff files.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an</p>	FA	<p>Policies and procedures are available to guide staff practice. A range of resources are available including to guide the assessment process of skin tears, pressure injuries and current wound care principals. There are sensor matts, a rotating air mattress and other specific mattresses available for</p>

appropriate standard.		<p>residents that are at risk of developing a pressure injury. Staff are provided with regular education opportunities.</p> <p>A family/whānau member noted staff had provided excellent service recently to another family member who has since 'passed away'. The resident's end of life care was reported to be timely, respectful and family/whānau were able to stay day and night as they wanted/needed. Staff were reported to look after the residents needs as well as the family/whānau.</p> <p>Most staff have had Covid-19 vaccinations and consenting staff and residents have had influenza vaccinations.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>As part of the admission process the next of kin/enduring power of attorney (EPOA) can identify what events they want communicated to them and when this communication is to occur. A completed 'family instruction for being contacted...' form was sighted in each resident's file and had been signed by the family/whānau member or EPOA. 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 in timeframes agreed and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>The facility manager knew how to access interpreter services through the local DHB if required, although noted interpreter services have not been required since their being employed at Te Mahana Resthome. All current residents can communicate effectively in English.</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>	FA	<p>The business plan for 2020-2022 outlines the organisations mission statement, intent, set of goals, and key stakeholders and their expectations. There are five key result areas in the strategic direction: honouring commitment to the shareholder; high quality care; family support; business viability and innovation; and practice excellence. The mission statement is: Te Mahana aim to support and promote the interests of the residents and to ensure the highest quality of care through honesty, integrity and vision.</p> <p>The facility manager provides a monthly report to the directors. The directors meet with the FM on a regular basis and discuss the activities undertaken at the facility. Review of documentation and interview of the FM and two of the directors confirmed this. The current directors advised they will be gradually stepping aside, and two new directors will take over and run the business by the end of 2021. The new directors are experienced in the aged care sector and are currently working in another</p>

		<p>aged care facility in the region with one in the position of quality manager and the other as the facility manager/enrolled nurse. The two new directors were present during the audit. There will be no change to the service provided. The directors stated HealthCERT is aware of the intended change of directorship.</p> <p>Te Mahana is managed by a facility manager who was appointed to the position in July 2020. Prior to this position the facility manager was an RN on the floor of a rest home/hospital aged care facility in the region for five years and worked one day a week as the RN for Te Mahana since 2018. The FM is interRAI trained and the RNs from the local medical centre who know the residents provide clinical support to the FM. The directors advised HealthCERT has been notified of the change of facility manager.</p> <p>On the first day of audit, 21 beds were occupied. The service holds contracts with the local DHB for aged related residential care including 19 at rest home level including one respite and one under the age of 65 years, one resident at hospital level and one boarder. A letter dated 2 June 2021 from HealthCERT acknowledged notification of the hospital level resident and sets out the conditions that are to be met, including advising HealthCERT by 1 September 2021 if the arrangement is still required.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>If the FM is temporary absent, a senior health care assistant fills the role with support for the clinical service from the RNs at the local medical centre situated across the road from the facility. Support is also available from the directors.</p>
<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>	<p>PA Low</p>	<p>The quality improvement plan July 2020-June 2022 has a commitment statement, quality assurance philosophy and objectives, two overall continuous quality improvement standards, quality improvement structures, quality methodologies to be used and outcomes to be achieved.</p> <p>Quality data for incident/accidents, satisfaction surveys internal audits, infections, medication errors, falls, skin tears and bruising are being collected and collated with graphs to show numbers. Corrective actions are developed and implemented with monitoring to make sure corrective actions have been effective.</p> <p>There was little evidence of quality data being analysed to identify any trends. The staff/quality</p>

		<p>meeting minutes and the FM's reports to the directors included numbers of clinical indicators only. Staff reported they do not discuss quality data at their meetings, including any trends, and do not see the graphs that are generated. This requires improvement.</p> <p>The satisfaction survey for 2021 evidenced residents and families were very satisfied with the service provided and all comments were complementary.</p> <p>Policies and procedures are fully embedded at Te Mahana. They are relevant to the scope and complexity of the service, reflected current accepted good practice. Policies and procedures are reviewed two yearly and were current. Staff are alerted to any new or reviewed policies and are available for staff to read and sign for. Staff interviewed confirmed this. Obsolete documents are removed and archived. Staff also confirmed the policies and procedures provide appropriate guidance for service delivery.</p> <p>The risk management plan 2020-22 identified analysis, evaluation and risk assessment. Actual and potential risks are identified and documented. The hazard register includes clinical, environment, staffing and cleaning and laundry hazards. One of the directors has overview of health and safety and it is intended that one of the new directors will take over the role of the health and safety representative. Both are responsible for the management of hazards, including putting in place appropriate controls to eliminate all hazards on site. The health and safety representative stated they have completed recent health and safety training and demonstrated sound knowledge. Staff confirmed they understood and implemented the documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Adverse, unplanned or untoward events are documented by staff on hard copy forms and are reviewed by the FM. The manager is responsible for the development of any corrective actions and close out. Review of the register, incident/accident reports and interview of staff indicated appropriate management of adverse events.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff are aware of essential notification responsibilities. The facility manager stated there have been no essential notifications to external agencies since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>Policies and procedures relating to human resources management are based on relevant legislation and good employment practices. Staff files reviewed included job descriptions which outline accountabilities, responsibilities and authority, employment agreements, references, completed</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>orientation, performance appraisals and police vetting.</p> <p>New staff are required to complete an induction prior to completing the orientation programme. The entire orientation process, including completion of competencies, takes up to 11 weeks to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Staff reported the orientation process prepared them well for their role.</p> <p>Health care assistants (HCA) are expected and supported to complete a New Zealand Qualification Authority (NZQA) education programme, level 2. One of the current directors is the Careerforce assessor for the facility and the new director/EN will take over the role. Staff are encouraged to complete further levels. Currently two HCAs have attained level two with four completing it and four have attained level 3 with two completing it.</p> <p>The education plan for 2021 was reviewed with a combination of sessions and online training. Training is also provided at handover and staff meetings. Competencies were current, including for medication, handwashing and restraint minimisation and safe practice. There is at least one staff member on each shift with a current first aid certificate. The FM is also first aid current.</p> <p>Staff files reviewed evidenced performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation. Staff also confirmed their attendance at on-going in-service education and that their performance appraisal was current.</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>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery.</p> <p>The FM works full time and is rostered on call after hours with back up from the RNs at the medical centre nearby. District nurses also provided input and support. The work force is stable after some staff resigned when the previous manager resigned in July 2020. There are two HCAs rostered on the morning shift with another HCA who combines care giving with providing activities. Three HCAs are on the afternoon shift (one being a short shift to help with settling residents in the evenings) and one HCA is on at night. The FM advised there is a casual pool of four HCAs available.</p> <p>The kitchen has two cooks and two tea aids who work over the evening meal service. There is a dedicated cleaner and HCAs share laundry duties.</p> <p>Observations during the audit confirmed adequate staff cover is provided, including residents being helped with meals in a timely manner. Residents, families and staff interviewed demonstrated</p>

		satisfaction with the staffing levels.
<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>	FA	<p>There is a paper based resident information management system in use. These records include financial documents and admission agreements. 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. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable by the resident's name. The facility manager advised all records are held for the required ten years after the resident has last exited services. Current residents' records in paper files were stored in locked stationery cabinets in the staff office. 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>The residents' clinical records sighted demonstrated that 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, with one exception. One resident was admitted with their spouse who had been assessed as requiring rest home level of care. This resident is noted by the facility manager as being 'a border'. Prospective residents and/or their family/whānau are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process in the information pamphlet, or via the 'Eldernet' website. Updated information from NASC or the GP is sought for any residents accessing respite care. There was one resident receiving respite care.</p> <p>Family 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 and assessments. A signed admission agreements in accordance with contractual requirements was present in four out of five residents' files sampled. The resident without an admission agreement was admitted prior to this facility manager's appointment. A review of four other residents' files that had been admitted at a similar timeframe all contained signed admission agreements. This is not raised as an area for improvement as it does not reflect a systemic issue. The facility manager advises the only additional resident charges are for hair dressing appointments by the visiting hairdresser. 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>	<p>FA</p>	<p>There is a discharge, exit, transition, or transfer process in place that is managed in a planned and co-ordinated manner, with an escort provided as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. 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 recently transferred to the local acute care facility showed that appropriate information was provided to enable continuity of care for the resident. The staff advise a copy of the current medicine chart, EPOA document (if applicable), and advance care plan is provided to the DHB along with information on the resident's allergies and next of kin contact details. The resident reported being kept well informed during their transfer.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC would be made. One resident has been recently assessed as hospital level care. The FM notes and a new placement was found, in consultation with the resident and whānau/family. The FM/RN is involved in the discharge process for residents including residents receiving respite care. The FM/RM advised a referral to the NASC service for a needs assessment is pending for a resident receiving respite services.</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>Te Mahana Resthome's medication management policy was current and identified all aspects of medicine management in line with the current legislative requirements. A paper-based medicine management system was in use and was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines had current medication management competencies.</p> <p>Medicine is stored in a lockable medication cupboard, and this includes the medication trolley when not in use. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The FM/RN checks medications against the prescription and the checks are recorded. All medications in use and in stock sighted were within current use by dates. The residents' medication charts had current residents' photos and allergies noted. There is a current staff signature list (full signatures and initials) inside the front cover of the medicine folder.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks (reported to be done with the pharmacist), and accurate entries.</p> <p>Staff are aware of the need to report medication errors and an appropriate corrective action plan was</p>

		<p>completed for the event sighted.</p> <p>Medicine fridge temperatures were monitored, and records maintained. While the records note the medication refrigerator temperature is consistently at zero degrees for the last six months, the thermometer at audit when checked was at 2 degrees Celsius. It is thought that the applicable staff were not reading the thermometer correctly. The FM/RN discussed this with staff during audit. Vaccines are not stored on site. The resident and staff influenza vaccination were facilitated by the GP practice. Staff are attending a nearby community vaccination centre for Covid-19 vaccinations. The FM/RN advised the 'mobile DHB vaccination team' are expected to provided residents with Covid-19 vaccinations as a group.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines. The requirements for pro re nata (PRN) medicines were met with infrequent exception (laxatives). This is not raised as an area for improvement as it is not a systemic issue. The required three-monthly medication reviews were consistently completed by the GP and recorded on the medicine chart. Residents and family/whānau are informed of changes to medicines prescribed as verified by interview.</p> <p>There were no residents self-administering medications at the time of audit.</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>FA</p>	<p>The food service is provided on site and is in line with recognised nutritional guidelines for older people. The menu follows seasonal patterns and summer and winter menus were reviewed by a qualified dietitian on 15 October 2020. Recommendations made at that time have been implemented. A diet requirements form is completed on admission for all residents and a copy is provided to the kitchen team. Copies of these were sighted in the kitchen folder. Residents' personal food preferences, allergies, special diet and modified texture requirements are made known to the kitchen staff and are accommodated in the daily meal plan. The main meal is serviced at lunchtime.</p> <p>The service operates with an approved food safety plan and registration issued by the local Council with an expiry 15 February 2022. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The kitchen and pantry were clean, and no food items were on the floor. There was no expired food in stock. All the decanted food in the fridge was covered and labelled. Special equipment, to meet resident's nutritional needs, is available. Staff have completed food safety training. Te Mahana Resthome is overdue their food verification audit. However, email communications with the local council note the council advised they have not been able to undertake food re-verification audits as initially planned due to resource issues and demand. A contractor has been recently employed by the local council to assist with food verification audits and Te Mahana Resthome is booked for their re-verification audit in August 2021. Copies of these email</p>

		<p>communications were sighted.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family/whānau interviews and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and resident's requiring assistance (including full assistance) had this provided in a timely manner.</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>	FA	<p>The facility manager reported that if a referral is received but the prospective resident does not meet the entry criteria, has care needs that cannot be met at Te Mahana Resthome, or in the event there is no vacancy, the local NASC would be advised to ensure the prospective resident and family/whānau are supported to find an appropriate care alternative. A wait list is not currently required. There is a clause in the admission agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Moderate	<p>Information is documented using validated nursing assessment tools, such as a falls risk, skin integrity and interRAI Momentum tool, as a means to identify any deficits and to inform care planning. Assessments are completed as required for sampled residents with the exception of the bowel chart and daily skin/wound assessment chart.</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 Moderate	<p>Some residents' care plans are not sufficiently detailed to guide care, and short-term care plans have not been consistently developed where required. However, despite this, the residents are receiving appropriate care as identified by the GP and RN, as the residents' care needs have been effectively communicated via other methods including shift handover. The long-term care plans in sampled files have been reviewed and signed by the resident or their family/whānau.</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>The reviewed documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The GP interviewed confirmed that medical input was sought in a timely manner and that medical orders are followed, and care is implemented promptly. Care staff confirmed that care was provided as outlined in the documentation and as discussed at shift handover. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>An activity programme is facilitated on site. While residents and family noted they were satisfied with the activities provided, the assessment form used to help identify individual residents' interests, hobbies and abilities to assist in the development of the activities programme has not been completed for two residents as required.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes by care staff. The RN reviews each residents' records on at least a weekly basis and notes this review. If any change is noted, it is reported to the RN and examples of this were sighted. Routine care plan evaluations occur every six months following the six-monthly interRAI reassessment, or sooner if the residents' needs change. Goals of care were reviewed and updated in response to evaluation of progress. Where the GP has requested laboratory investigations to be completed, the results are evaluated and actioned. Changes have been made to medications prescribed in response to psychogeriatrician and mental health staff input. The GP and podiatrist document an evaluation during each resident's consultation.</p> <p>Monthly vital signs and weights have been recorded for residents and the results appropriately actioned for sampled residents. Blood glucose levels are monitored where applicable and the international normalised ratio (INR) blood tests conducted as requested by medial staff.</p> <p>Staff are informed of any changes to the plan of care at verbal handovers. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals were referenced in residents' files, including to mental health/psychogeriatrician, and wound care nurse specialist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews with residents and family/whānau. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. A resident was referred to the DHB for inpatient assessment in response to altered laboratory results (refer to 1.3.3).</p>
<p>Standard 1.4.1: Management Of</p>	<p>FA</p>	<p>The waste management and hazardous substances management policy contains all expected</p>

<p>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>		<p>information for the safe management and disposal of household and body waste and use of hazardous substances. The policy meets the requirements of the standard including labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted and are accessible for staff.</p> <p>Protective clothing and equipment were sighted that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed at the front entrance that expires on the 26 August 2021. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Residents and families confirmed they can move freely around the facility and that the accommodation meets their or their relative's needs. Passageways are wide enough for residents to pass comfortably.</p> <p>There is a proactive and reactive maintenance programme, and the buildings, plant and equipment are maintained to an adequate standard. Maintenance is undertaken by the trust that owns the building and the directors who own the business. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. Hot water temperatures at resident outlets are maintained within the recommended range.</p> <p>There are external areas available that are appropriate to the resident groups and setting. Seating and shade are available for residents to frequent areas. The environment is conducive to the range of activities undertaken in the areas. The site is flat, and residents are protected from risks associated with being outside.</p> <p>Health care assistants confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</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</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Two rooms have individual full ensembles and all other rooms have a wash hand basin. There are additional toilets and showers near the residents' rooms. Bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. Separate bathrooms for staff and visitors are available.</p>

assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms provide single accommodation. There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. Rooms are personalised with furnishings, photographs and other personal items on display. All bedrooms are large enough for residents and staff and equipment to manoeuvre within.</p> <p>There is adequate room in the facility to store mobility aids, such as mobility scooters, wheelchairs and walkers.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Various communal areas are available for residents to frequent. The dining room and lounge areas have good space and enable easy access for residents and staff. Residents can access areas for privacy. The furniture in the lounges and dining room is appropriate to the setting and residents' needs.</p> <p>There is adequate space to accommodate equipment in the dining room and lounges. The large main lounge is used for planned activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</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>All laundry is undertaken on site. Staff demonstrated a sound knowledge of the cleaning and laundry processes. The cleaning of the facility is to an adequate standard. Chemicals are stored securely and were in appropriately labelled containers and in a closed chemical system. The cleaning trolley is stored securely when not in use. The representative from the chemical company visits monthly. Residents and families interviewed reported personal clothes are managed effectively and returned in a timely manner. There are separate named baskets for each individual resident. Cleaning and laundry processes are monitored through the internal audit programme and by the representative from the chemical company.</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>	FA	<p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 17 April 2017. A fire evacuation drill takes place at least six monthly with a copy sent to the New Zealand Fire Service. The last trial was held on the 17 June 2021. The orientation programme and ongoing training includes fire safety, emergencies and security. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Policies and procedures and guidelines for all emergency planning, preparation and response are</p>

		<p>displayed and flip charts are displayed throughout the facility to guide staff. Disaster and civil defence planning guides direct the facility in their preparedness for disasters and described the procedures to be followed in the event of a fire or other emergency. A business continuity plan is in place.</p> <p>Adequate supplies for use in the event of a civil defence emergency including food, water, blankets, torches, mobile phones and a gas barbecue were sighted and meet the requirements for the number of residents able to be accommodated at the facility and staff. Water is stored in a tank and more than meets the requirements for the emergency water storage recommendations for the region. Emergency lighting is battery powered and checked regularly.</p> <p>Call bells alert staff to residents requiring assistance. Call bells were observed in service areas within the facility. Residents stated they are answered in a timely manner.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the facility is checked by staff. Sensor lights are situated externally.</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 comfortable temperature.</p>	FA	<p>Heating is provided by gas ducting which comes through the ceiling. Bedrooms also have individual electric wall heaters. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. Both the building and outside areas are smoke free.</p>
<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 has implemented 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 is reviewed annually; it was last reviewed on 16 February 2021.</p> <p>The facility manager/registered nurse is responsible for facilitating the infection prevention and control programme. The role and responsibilities are detailed in a position description.</p> <p>There was signage at the main entrance to the facility requesting anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Hand sanitiser and the COVID-19 tracer app for contact tracing was accessible at the main entrance. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The interviewed staff understood these responsibilities.</p> <p>Consenting residents and staff are offered annual influenza vaccinations. Covid-19 vaccinations are</p>

		<p>underway for staff, and pending for residents. The FM/RN advises the residents and family have been consulted and applicable consents obtained.</p> <p>Appropriate personal protective equipment is available for staff and posters in the main office detail the correct sequence and process for 'donning' and 'doffing'.</p>
<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 FM/RN has been in this role for approximately 12 months and has completed relevant infection prevention and control education through 'webinars', online videos and the Ministry of Health, DHB and sector Covid-19 information updates. The FM/RN advised additional support and information would be accessed from the infection control team or public health service at the DHB, the community laboratory, the GP as and when required. The FM/RN has access to residents' records and diagnostic results via the GP practice to ensure timely treatment and resolution of any infections.</p> <p>There are processes in place for COVID-19 pandemic preparedness. Adequate resources to support the programme and any outbreak of an infection were available on site.</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 reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2020. A site-specific pandemic plan with current reviews and updates was sighted.</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 gloves. Hand washing and sanitiser dispensers were 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 to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation, and as part of the ongoing education programme, and includes hand hygiene competency. Education is provided by the FM/RN and via on-line videos. Staff training records were sighted in the staff records sighted by the lead auditor.</p> <p>One on one education was provided to residents and has included reminders about handwashing, and</p>

		urinary tract infection prevention as noted in residents' records sampled. Other information is communicated on influenza and Covid-19 vaccination via brochures and consent processes. Infection prevention and control topics has also been discussed at residents' meetings. Residents, and where applicable family/whānau members, are informed of all residents' infections, as verified by resident and family/whānau interviews.
<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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, gastro-intestinal and the upper and lower respiratory tract. All infections are recorded on a monthly infection register by the FM/RN. New infections and any required management plan are discussed at handover, to ensure early intervention occurs, and these are noted in the communication book. This was observed during audit and verified by the care staff interviewed.</p> <p>Monthly surveillance data is collated. However, themes and trends are not being communicated to staff. This is included in the area for improvement raised in criterion 1.2.3.6.</p> <p>There has not been an infection outbreak 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>The service demonstrated the use of restraint is actively minimised. Equipment used includes sensor mats. There were no residents using a restraint or enablers during the audit. One resident was using a restraint a day prior to the audit and the family of the resident had agreed to a trial period for their relative without using restraint. The FM stated the aim is to have no restraint used in the facility. Policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The service has policies and procedures in place to guide staff in the management of restraints. The restraint co-ordinator demonstrated a sound knowledge relating to minimising restraint use, current and potential risks of restraint, the approval process, and monitoring and review of the restraint process.</p> <p>Restraint is included in the staff/quality meetings. Review of the minutes confirmed this. Required documentation relating to restraint and enabler use is recorded.</p> <p>The restraint approval process is being followed and a current consent was in place for the use of restraint. Bedrails and lap belts have been approved.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The resident's care plan of the one person using restraint immediately prior to the audit, evidenced a detailed assessment including risks associated with restraint use.</p> <p>The restraint checklist and consent was evidenced in the resident's file. Close monitoring and review of the ongoing requirement for restraint was documented with possible alternatives and strategies which are discussed with family and staff including the decision to trial not using a lap belt for the one resident.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The restraint coordinator stated that restraints are used as a last resort after alternative interventions have been explored. The restraint register is current and meets the standard.</p> <p>Documentation in the resident's file relating to risk around restraint was individualised and gives good detail including the trial not to use restraint.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Evaluation and review of restraint meets the standard. The restraint coordinator confirmed communication with family is held regarding any restraint. Discussions have been held with the family around stopping their relative's restraint as a trial. The family interviewed confirmed this.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Quality review of restraint is managed through the internal audit programme and the quality/staff meetings. Review of documentation and interview of the restraint coordinator confirmed this.</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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Quality data is being collected and collated including, but not limited to, incident/accidents, satisfaction surveys internal audits, infections, medication errors, falls, skin tears and bruising. Month by month graphs are generated. There was little evidence that quality data is being analysed to identify any trends. The staff/quality meeting minutes and the FMs reports to the directors included numbers of clinical indicators only. Staff reported they do not discuss quality data at their meetings including any trends and do not see the graphs that are generated.	Quality data is not being comprehensively analysed to identify any trends, and results including graphs are not being reported to staff and the directors.	Provide evidence that quality data is comprehensively analysed to identify trends and reported back to staff and the directors. 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of	PA Moderate	The sample of care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed and the residents' needs were communicated to staff. Residents and family/whānau confirmed their	Bowel charts and daily skin/wound care assessments are not consistently being	Ensure bowel charts and daily skin / wound assessments are

<p>consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>		<p>involvement in the assessment process. Following a fall neurological monitoring was undertaken when required – as sighted by the lead auditor in post fall follow-up. A behaviour monitoring chart is used for applicable residents. Bowel charts are also used to monitor residents' elimination. These were not adequately completed for the resident receiving hospital level care (refer to 1.3.3) and one other file sampled. For one resident the records noted a gap of over a week between bowel motions. This was thought by the FM/RN to be incorrect.</p> <p>Wound charts are in use to document and monitor residents with wounds. This includes assessment of wound size, exudate, granulation, slough and pain. The RN has reviewed residents' wounds and completed the full assessment wound chart weekly. However, the daily skin assessment and management of one resident's skin (refer to 1.3.3) is not consistently being documented with a gap of five days noted on two separate occasions in the last month.</p>	<p>completed where indicated.</p>	<p>consistently undertaken as clinically indicated.</p> <p>90 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>An initial care plan is required to be developed within 24 hours of admission. These were present in four out of five sampled residents' files and missing from one resident's records. Long term care plans were developed within three weeks of admission. However, these are not sufficiently detailed to guide care for some residents. Aspects not sufficiently detailed in sampled records included blood glucose management, dietary needs (two residents), and a fluid restriction. One resident that identifies as Māori did not have the Te Whare Tapa Wha care plan available which was referenced in the long-term care plan to identify the resident's cultural needs. Short term care plans have been developed for a resident with a wound and for a resident with challenging behaviour; however, have not been developed for a resident with an infection and a resident at increased risk of skin integrity issues.</p>	<p>Some residents' care plans are not sufficiently detailed to guide care. For example, a resident requiring insulin does not have any information in the care plan on the frequency blood glucose levels are to be tested, the target blood glucose range, the process for managing blood glucose levels when outside of the accepted range, dietary and fluid needs.</p> <p>The 'Te Whare Tapa Wha' care plan for a resident that identifies as Māori</p>	<p>Ensure the residents' long term care plans are sufficiently detailed to guide the individual resident's care, including where applicable, cultural needs.</p> <p>Ensure short term care plans are developed when new care needs are identified.</p>

			<p>could not be located in the resident's records.</p> <p>Short term care plans are not consistently developed to guide staff care for short term issues when these are identified.</p>	90 days
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>The activities programme is provided by the activities coordinator Mondays to Friday from 10.30 am to 11.45 am. The activities programme is completed by a healthcare assistant responsible for facilitating the activities programme with the support of the facility manager. The activities programme is discussed at the monthly residents' meetings. This was verified in the residents' meeting minutes sighted.</p> <p>A social assessment and history assessment is required to be completed within two weeks of admission via the assessment form provided to residents or family/whanau to ascertain residents' needs, interests, abilities, and social requirements. The activities coordinator advised the FM/RN completes this assessment using the information from the resident and family/whānau, and observation, however a completed form was not present for two residents. A copy of the monthly activities plan is given to each resident each month and summarised for the week on the notice board in the lounge/dining room. The residents' participation is evaluated six-monthly as part of the formal six-monthly care plan review, and annual multidisciplinary review.</p> <p>The activities on the calendar reflected residents' goals, ordinary patterns of life and included normal community activities and festive occasions (eg, St Patricks day, Mother's Day and Easter). Individual, group activities and regular events are offered. Residents' birthdays are celebrated with the resident provided a gift and a birthday cake. The activities on the programme included at least fortnightly outings and church services, special occasion celebrations, visiting entertainers, games and exercises. The library visits regularly and</p>	<p>Two out of five residents did not have the applicable self-assessment completed to identify interests, hobbies and abilities to help inform the activities programme.</p>	<p>Ensure assessments are completed for all residents detailing their interests, hobbies, and abilities and this is used to help inform the development of the activities programme.</p> <p>180 days</p>

		<p>swaps out books available on site for residents to read.</p> <p>Daily activities attendance records were maintained, and residents were observed participating in various activities on the days of the audit. The interviewed residents confirmed they find the programme satisfactory. Family/whānau interviewed were happy with the activities options available.</p>		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.