

# Papatoetoe Healthcare Limited - Papatoetoe Residential Care

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Papatoetoe Healthcare Limited

**Premises audited:** Papatoetoe Residential Care

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 15 December 2021 End date: 16 December 2021

**Proposed changes to current services (if any):** There is a proposed change of ownership. The date for the sale of Papatoetoe Residential Care to become unconditional is planned for 21 January 2022, and change of ownership occurring on 1 February 2022.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 28

# Executive summary of the audit

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## Introduction

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

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

## General overview of the audit

Papatoetoe Residential Care Ltd provides care for up to 30 residents requiring aged residential rest home and hospital level care. At the time of this audit 28 residents were receiving care.

This provisional audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board, as the care home is being sold. The planned unconditional date for the sale of the Papatoetoe Residential care is 21 January 2022, with change in ownership planned for 1 February 2022. The audit process included the review of policies, procedures, residents' and staff files, observations and interviews with residents, families, a general practitioner, managers, and staff. A telephone interview also occurred with the prospective owner and the intended new facility manager. Residents and family members interviewed expressed satisfaction with the services provided.

There are six areas identified for improvement related to the current facility manager education / prospective owner aged related residential care contract knowledge, essential notifications, registered nurse staffing, overdue interRAI assessments, activities

documentation and medicine competencies records. The area requiring improvement related to medicine management at the last audit has been addressed.

## **Consumer rights**

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

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

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

Complaints are managed in a timely manner by the facility manager.

## **Organisational management**

The organisation's philosophy, mission and vision statement are documented, along with goals. The executive director (who is one of the facility owners), the facility manager and the clinical nurse leader work together to ensure service planning covers all aspects of service. The services offered meet residents' needs, legislation, and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit programme, complaints management, incident/accident reporting, hazard and risk management, and regular resident and staff meetings. Corrective action planning is documented.

New staff have an orientation relevant to their role. Ongoing education is provided at least monthly. Records of attendance are maintained. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that all their needs and wants are met. The service has a documented rationale for staffing.

The prospective owner owns another aged care facility in Auckland and has an experienced aged care facility manager that will manage both this facility and the other care home already owned, with the support of the clinical nurse leader. The prospective owner plans to continue employment of existing staff and implement the existing quality and risk programme.

Individual residents' records are maintained. Resident information is sufficiently documented to ensure safety and continuity. All records are secure.

## **Continuum of service delivery**

Papatoetoe Residential Care policies and procedures provide documented guidelines for access and entry to service. All residents are assessed before entry to the service to confirm their level of care required. The nursing team is responsible for all assessments, care planning, and evaluation of service delivery plans. Care plans are individualised and based on the residents' assessed needs and basic routines. Interventions developed are appropriate and evaluated as per policy requirements. The ongoing evaluation process ensures that assessments reflect the residents' status.

The activities programme identifies the needs and interests of the residents as individuals and in group settings, including younger people with disabilities (YPD). In interviews, residents and family/whānau expressed satisfaction with how activities are conducted at the service and the activities programme in place.

There is a safe medicine management system. All medications are reviewed by the general practitioners (GPs) every three months.

The food service provides for specific dietary likes and dislikes of the residents. Nutritional requirements are met. Nutritional snacks are available 24 hours a day.

## **Safe and appropriate environment**

The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substance.

There are documented emergency management response processes which are understood and implemented by staff. This includes fire drills.

The building has a current building warrant of fitness and an approved fire evacuation plan. There have been no significant changes to the facility since the previous audit except for some ongoing refurbishment as bedrooms become vacant.

The facilities meet residents' needs and provide furnishings and equipment that are regularly maintained and updated. Bedroom areas allow residents to move around with or without assistance. There are adequate toilet, bathing and hand washing facilities. Employed staff are responsible for cleaning the care home. Laundry services are contracted out.

The lounge and dining areas meet residents' relaxation, activity and dining needs. Appropriate external areas are available for residents' use.

The facility is kept at a suitable temperature, and is appropriately ventilated, and has security processes in place.

## **Restraint minimisation and safe practice**

The organisation has implemented policies and procedures that support restraint minimisation. Three residents had restraints in use at the time of audit. A process of restraint related assessment, approval, monitoring and regular review occurs.

No enablers were in use. Use of enablers is voluntary for the safety of residents in response to individual requests.

Staff were able to details their responsibilities when caring for residents with restraints and enablers in use.

## Infection prevention and control

The infection control management system minimises the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating the education and training of staff. Infection data is collated monthly, analysed, and reported during staff meetings.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service and are 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)
<b>Standards</b>	0	44	0	3	3	0	0
<b>Criteria</b>	0	95	0	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Papatoetoe Residential Care has policies and procedures to meet its obligation under the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training was verified in the training records. The Code is displayed around the facility and provided to residents and family/whānau as part of the admission process. The registered nurses (RNs) confirmed that compliance with the requirements of the Code is met in all aspects of care.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled verified that informed consent had been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of</p>

		<p>attorney (EPOA), where applicable. The general practitioner makes a clinically based decision on resuscitation authorisation. On review of residents' files, one file had no completed consent in place. The sample was extended, with two additional files added to the sample, verifying that this was not a systemic issue, and therefore not raised as an area requiring improvement. The RN reported that this one case had been delayed because of the suspected Covid-19 event at the facility.</p> <p>Staff were observed to gain consent for day-to-day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</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>As part of the admission process residents and family/whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents were aware of the advocacy service, how to access this, and their right to have support persons. The RNs and staff provided examples of the involvement of advocacy services concerning residents' care.</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, shopping trips, activities, and entertainment, if allowed depending on the National Covid-19 alert level in place at the time. Younger people with a disability are assisted in accessing community resources and mainstream supports. There has been a prolonged period where residents did not leave the premises except for health related appointments, due to Covid-19 precautions. Family/whānau or friends are encouraged to visit or call. In person visiting was restricted as per the National Covid-19 alert levels.</p> <p>The facility normally has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff. In person visiting has recently recommenced,</p>



		with staff and visitors required to follow specific processes to reduce Covid-19 related risks.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints/compliments policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission. Residents and family members interviewed advised they have been provided with information on the complaints process and had not made any complaints.</p> <p>The complaints register reviewed showed that two complaints have been received since the last audit (March 2021). The actions taken, through to an agreed resolution, were clearly documented and completed within the timeframes. Action plans showed any required follow-up. The facility manager is responsible for complaints management and follow-up. The executive director assists with any significant / external complaint review and response.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from the District Health Board, Ministry of Health or Accident Compensation Corporation since the last audit. A complaint from the HDC on 13 November 2019 (prior to the last audit) remains open. The management team have provided all information requested.</p> <p>The prospective provider: The prospective owner and their new facility manager are aware of the complaints management process, and timeframes as required by The Code.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information about consumer rights legislation, advocacy services, and the complaints process are provided on admission and displayed at the reception. The Code is available in te reo Māori and English languages. Family members and residents interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process.</p> <p>The admission pack outlines the services provided. Resident</p>

		<p>agreements, signed by an enduring power of attorney (EPOA) and residents, were sighted in records sampled. Service agreements meet the district health board contractual requirements.</p> <p>Prospective provider: The prospective owner is a medical practitioner and confirmed familiarity with the Code. The prospective owner has employed a facility manager who is experienced in aged related residential care services and on how the Code is to be implemented in this service setting.</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>There is a policy and procedure regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms, and reporting requirements. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice.</p> <p>Residents' privacy and dignity are respected. Staff was observed maintaining privacy.</p> <p>A physiotherapist (PT) visits to conduct the physiotherapy programme with help from the caregivers. Residents are supported to maintain their independence including residents assessed as requiring rest home and hospital care, and for younger people with disabilities. All residents were able to move freely with no restrictions.</p> <p>Records sampled confirmed that each resident's individual cultural, religious, and social needs, values, and beliefs had been identified, documented, and incorporated into their care plan.</p>
<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</p>	<p>FA</p>	<p>Papatoetoe Residential Care acknowledges its responsibility in its current operations to Māori residents. The RN confirmed that the service responds in accordance with the Treaty of Waitangi taking into consideration He Korowai (Māori Health Strategy) and Whakatataka</p>

individual and cultural, values and beliefs.		(Māori Health Action Plan 2020-2025). Assessments and care plans document any cultural and spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. Cultural staff training is incorporated into the staff annual in-service education calendar. Some residents identifying as Māori had their cultural needs identified in care plans. There were staff members of Māori descent. Policies and procedures regarding the recognition of Māori values and beliefs are documented.
<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	Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner following protocols/guidelines as recognised by the resident and family/whānau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents confirmed they were encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in the care plans reviewed.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Family members stated that residents were free from any type of discrimination, harassment, or exploitation and felt safe. Residents interviewed reiterated the same. The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of conduct. A code of conduct statement is included in the staff employment agreement. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The facility manager (FM) stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	The service encourages and promotes good practice through the ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP)

		<p>confirmed promptness and appropriateness of medical intervention when medical requests are sought.</p> <p>Staff reported they receive management support for external education and access their professional networks to support contemporary good practice. The majority of care staff have a New Zealand Qualifications Authority (NZQA) level four qualification or equivalency (refer to 1.2.7).</p> <p>RNs reported that they have been trained in outpatient antimicrobial therapy (OPAT) administering intravenous antibiotics to patients transferred for a short stay from the local district health board.</p> <p>The activities programme catered for residents assessed as requiring rest home and hospital level of care, and for those under 65 years of age. However, an improvement is required in developing and evaluating care plans in a timely manner (Refer 1.3.7.1).</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>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures. Personal, health, and medical information is collected to facilitate the effective care of residents.</p> <p>The RN reported that a variety of external resources, including support groups and interpreter/translation services, are accessed as required. The staff further reiterated that residents and relatives who are not conversant with the English language are advised of the availability of interpreter services at the first point of contact. There were no residents who required the services of an interpreter; however staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are</p>	PA Low	<p>The business plan reviewed annually was dated 2021 to 2022. The business plan outlines the purpose, values, scope, direction and goals</p>

<p>planned, coordinated, and appropriate to the needs of consumers.</p>		<p>of the organisation and was developed by the executive director. The documents described annual and longer-term objectives and the associated operational plans. Papatoetoe Residential Care site specific objectives were also clearly documented in the business plan sighted. The business plan is linked to the Business Risk Management Plan, that was last reviewed in December 2021. The executive director can access occupancy and accounts data in real time. The facility manager provides monthly reports to the executive director, emerging risks and issues, and quality (clinical) indicators (refer to 1.2.3), results of internal audits and concerns/variations to expected service delivery. The executive director confirms the facility manager brings any new issues or concerns to her in a timely manner via email or phone. The facility manager and clinical nurse leader are experienced in the aged residential care sector.</p> <p>The care home holds contracts with Counties Manukau District Health Board (CMDHB) for age related residential care (ARRC), respite, rest home, hospital, palliative care, and long term support chronic health conditions (LTSCH). The facility manager advised there is also a contract for primary options for acute care (POAC) and outpatient antimicrobial therapy (OPAT), although there were no residents receiving care under these two contracts at the time of audit. There is also a contract with the Ministry of Health (MOH) for younger people with disabilities (YPD). On the first day of the audit, 28 residents were receiving services; one at rest home level of care and 27 at hospital level care. The hospital level care residents included one under the younger persons with disability (YPD) contract, three residents under the long LTCHC contract, two residents funded by Accident Compensation Corporation (ACC), and 21 under the ARRC (long term care) contract.</p> <p>Staff were informed of the proposed sale of the care home by the current owner on the first day of the audit, as staff had a planned gathering. The current owner stated she would develop a letter for residents and family members and planned to issue this within 48 hours.</p> <p>Ensuring the manager completes at least eight hours of applicable education per annum, and that the prospective owner has appropriate knowledge of the aged related residential care contract areas</p>
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		<p>requiring improvement. This finding has been rated as low risk as the current facility manager will be retiring shortly after the proposed sale; and the prospective owner has owned another ARRC facility since 2016 employing an experienced facility manager that will work across both care homes. A timeframe of one month is given to action this finding to enable the prospective owner to further contract related discussions with the DHB portfolio manager prior to purchase/commencing services.</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>	FA	<p>In the facility manager's absence, the clinical nurse leader carries out all the required duties under delegated authority. During absences of key clinical staff, the oversight of clinical services is the responsibility of a senior registered nurse who is experienced in aged-related care and has current interRAI competency. Additional support is provided by the executive/director who has owned this care home since 2011. Staff interviewed confirmed the current arrangements work well.</p> <p>Prospective Owner: The prospective owner advised that the CNL will continue to be in charge in the new facility manager's absence, as is currently occurring.</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>	FA	<p>Papatoetoe Residential Care has a quality and risk management system which is understood and implemented by staff. This includes internal audits, incident and accident reporting, health and safety reporting, hazard management, infection control data collection, restraint minimisation and complaints / compliments management. Regular internal audits are conducted and the results of seven audits sampled demonstrated a high level of compliance with organisation policy.</p> <p>If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions were developed and implemented. Quality information is shared with all staff via shift handover as well as via the monthly staff meetings. The meeting minutes sampled included relevant quality and risk issues and adverse events, infection and restraint use related data.</p>

	<p>A resident satisfaction survey was documented as being undertaken in April 2021. The results of this survey could not be located. However, regular meetings are held monthly with residents to obtain resident feedback on services, food, and activities as well as to obtain information for future planning. The minutes of four recent meetings were sighted.</p> <p>Policies and procedures were readily available for staff in paper copy. There is an implemented process to ensure regular review and updating of contents, documentation control, and communication of key changes to staff. The executive director reviews and approves or amends the final document before release. Documents sighted during audit had been reviewed in January 2021.</p> <p>Staff, residents and family members interviewed expressed satisfaction about the services provided at Papatoetoe Residential Care.</p> <p>Actual and potential risks are documented and reviewed by the executive director most recently in December 2021. Mitigation strategies have been documented, with Covid-19 and staffing specific risk management strategies updated. The executive director confirmed the facility manager communicates new and changing risks in a timely manner.</p> <p>Staff confirmed that they understood and implemented documented hazard identification processes. The hazard register sighted was up to date. Maintenance issues are reported and addressed as issues are identified. Staff health and safety representatives have been elected and are working with staff and the management team. The Health and Safety Committee met in July 2021 and the meeting included a review of the facility's emergency response following a recent tornado that caused loss of power and review of hazards (refer to 1.2.4.2 and 1.4.7).</p> <p>Prospective Provider:</p> <p>The prospective owner and the intended new facility manager were interviewed. Both advised that the existing policies and procedures, health and safety and quality and risk systems would continue to be implemented. There are no immediate or short-term plans to make any changes, and over time they would seek to review the quality and risk process and policies / procedures with the other care home owned and standardise systems and processes where appropriate and able across</p>
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		the two services.
<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>PA Moderate</p>	<p>A policy/procedure details the required process for reporting incidents and accidents. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as part of the ongoing education programme, and during staff meetings</p> <p>Applicable events are being reported in a timely manner and disclosed with the resident and/or designated next of kin. This was verified by residents and all family members interviewed. Applicable events in sampled residents' files had been reported via the incident and accident reporting system. A review of reported events, including a staff injury, resident falls (witnessed and unwitnessed), challenging behaviour, bruising, a medicine error, and a pressure injury, demonstrated that incident reports are completed, investigated, and responded to in a timely manner. Completed incident reports are filed in the resident's individual clinical record. There has not been any significant increase in the number of adverse events reported since the RN rostering changes were introduced (refer to 1.2.8.1), according to the August to October 2021 incident report summary data sighted. The November 2021 data is currently being compiled. Staff communicated incidents and events to oncoming staff via the shift handover. A summary of reported events and any required actions was discussed with staff at the staff meetings. Although the management team can detail the type of events that are to be reported, not all applicable events are being reported and this is identified as an area requiring improvement.</p> <p>Prospective Provider:</p> <p>The facility manager employed by the prospective provider could detail the types of events that require reporting as essential notifications and to whom.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment</p>



<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>process includes staff completing an application and health questionnaire referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation`s policies are being consistently implemented and records are maintained. Registered and contracted registered health professionals maintain a current APC. There are staff who have worked in this care home for between 10-20 years.</p> <p>Staff orientation includes all necessary components relevant to the role. New staff members reported that the orientation programme was thorough and included the facility, equipment, policies and procedures, individual resident`s care needs and emergency management. Staff files reviewed verified that orientation has been completed as required. Staff records reviewed showed documentation of a completed performance review after three months and then annually thereafter. The RN appraisals are scheduled. Records were not available to demonstrate one of the RNs has a current medicine competency. This is raised as an area for improvement in 1.3.12.3.</p> <p>There is a documented orientation for bureau/agency staff and records of completion were sighted, most recently in July 2021.</p> <p>Continuing education is planned at the facility annually with mandatory training requirements being covered in addition to any site-specific needs. This includes some on-line education as well as practical / in person education. The executive director and facility manager advised all except three caregivers have completed a level four New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider`s agreement with the Counties Manukau District Health Board / or have a qualification based on time worked in the sector. The other three caregivers have completed level two requirements.</p> <p>The registered nurses have a current first aid certificate.</p> <p>The facility manager keeps records of completed staff education, with the assistance on the CNL.</p> <p>The prospective provider: The prospective owner and their new facility manager advised the current recruitment processes and training</p>
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		programme will continue as is.
<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>PA Moderate</p>	<p>There is a documented 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 adequate staff available to complete the work allocated to them. Residents and family interviewed were satisfied residents care needs were being attended to in a timely manner. Difficulties recruiting registered nurses and obtaining agency/bureau staff has resulted in an area for improvement related to RN rostering. A new RN has been recruited and will start at the end of December that will help address this issue.</p> <p>The clinical nurse leader and one other RN have current interRAI competency.</p> <p>Prospective provider: The prospective provider stated there is no intention to reduce / change the current rostering arrangements. The prospective owner and their facility manager were aware there have been some challenges recruiting registered nurses, with an overseas RN employed to start at the end of December 2021. They identified another registered nurse is currently being recruited to work in their current care home, and there is the potential of an RN working across the two care homes in the future if needed.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files reviewed identify that information is managed in an accurate and timely manner. Residents' records are held both electronically and paper-based. The staff have individual passwords to the residents' records database, such as the medication management system and on the interRAI assessment tool. The visiting GPs and allied health providers also have access to the system which supports the integration of residents' records.</p> <p>Some residents' records are maintained in hard copy. This includes the admission agreement, consent agreements, and the current care plans.</p>

		<p>All hard copies are kept securely in the locked cupboards. Hard copy archived records are stored safely and securely on-site. There is an effective system for retrieving both hard copies and electronically stored residents' records.</p> <p>All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift.</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 service's admission policy for the management of inquiries and entry is in place. Papatoetoe Residential Care admission pack sighted contained all the information about access and entry to the service. Assessments and entry screening processes are documented and communicated to the family/whānau of choice, where appropriate, local communities, and referral agencies.</p> <p>Files sampled evidenced that completed Needs Assessment and Service Coordination (NASC) service authorisation forms were completed before entry for all residents admitted under different levels of care. Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry.</p> <p>The family/whānau and residents interviewed confirmed that they received sufficient information regarding the services provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. The RN reported that all required documentation for transition, exit, discharge, or transfer is completed for hospital, rest home, and YPD residents including those on the primary options for care contract and the outpatients antimicrobial therapy contract.</p> <p>Residents and their families are involved in all exits or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</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>PA Low</p>	<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.</p> <p>Indications for use are noted for pro re nata (PRN) medications, allergies are indicated, and photos were current. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from the hospital or any external appointments. The RNs check medicines against the prescription and these were updated on the pharmacy delivery forms.</p> <p>The GPs complete three monthly medicine reviews.</p> <p>There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. Monitoring of medicine fridge and medication room temperatures were conducted regularly and deviations from normal were reported and attended to promptly. Records were sighted.</p> <p>The RN was observed administering medications safely and correctly. Medications were stored safely and securely in the trolley and locked treatment room.</p> <p>There were two residents self-administering medications, such as inhalers, and they had been assessed as competent to do so. These were stored securely in the residents' respective rooms.</p> <p>The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted. Administration records are maintained, and drug incident forms are completed in the event of any drug errors.</p> <p>Outcomes of as-required (PRN) medication were consistently documented. This previous area requiring improvement was addressed. Annual medication competencies were completed for applicable staff except for one RN.</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 kitchen service complies with current food safety legislation and guidelines. The food service is managed by a chef and a cook with help from a kitchen hand. There is an approved food control plan for the service which expires 11 March 2022. Meal services are prepared on-site and served in the respective dining areas. The menu was reviewed by the registered dietitian on 2 November 2020. The kitchen staff have current food handling certificates.</p> <p>Diets are modified as required and the cook confirmed awareness of the 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' weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night 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. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers are maintained.</p> <p>The residents and family/whānau interviewed indicated satisfaction with the food service.</p> <p>All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The FM reported that all potential residents who are declined entry are recorded and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The person/family is referred to the referral agency to ensure the person will be admitted to the appropriate service provider.</p>
<p>Standard 1.3.4: Assessment</p>	<p>FA</p>	<p>Residents have their level of care identified through the needs assessment carried out by the NASC agency. All residents'</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>assessments covered the physical, psycho-social, spiritual, and cultural aspects of each resident. Admission and interRAI assessments are completed utilising information gained from either the resident, the nominated family representative, referring agency and/or the previous provider of health, other health team members, observations and examinations carried out by the nursing team.</p> <p>Assessments and care plans sampled were detailed and care staff reported that interventions developed were easy to follow. Some of the ongoing reviews completed did not meet time frames that safely meet the needs of the residents or ARCC contract requirements (refer 1.3.3.3). All outcomes from interRAI assessments and other additional assessments were identified and addressed in the care plans sampled.</p> <p>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>	<p>FA</p>	<p>The assessment findings and input from the resident and/or family/whānau informed the care plan and assisted in identifying the required support to meet residents' goals and desired outcomes. Plans sampled were resident-focused and stated actual or potential problem/deficits, set goals for meeting these, and detailed required interventions. Short-term care plans were used for short-term needs, and these were reviewed weekly or as required, as sighted in the sampled files reviewed.</p> <p>The review process determined the effectiveness of the interventions in ensuring the resident is achieving set goals. The care plans are amended, as necessary, to ensure the interventions and goals were appropriate and achievable.</p> <p>The RN reported that behaviour management plans were implemented as required, especially for residents presenting with any behavioural issues of concern. Family/whānau and residents confirmed they were involved in the care planning process. YPD residents have person-centred support plans in place and community involvement is encouraged.</p> <p>Residents' files demonstrated service integration and evidence of allied</p>

		healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapists, district nurses, dietitians, and GPs.
<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>All residents' files sampled evidenced that care plans developed had interventions that were relevant and adequate to address the identified needs of residents.</p> <p>Any residents' changing needs were reported in a timely manner and prescribed orders were carried out. The RN reconfirmed that the GP's medical input was sought within an appropriate timeframe, medical orders were followed, and care was person-centred. This was further reiterated by the GP in the interview conducted. Care staff confirmed that care was provided as outlined in the care plan.</p> <p>A range of equipment and resources are available, suited to the level of care provided and following 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>	PA Moderate	<p>The activity programme is formulated by the activities coordinator in consultation with the nursing team. The activities are varied and appropriate for people assessed as requiring hospital or rest home level of care, including younger people with disabilities (YPD). The residents were observed participating in a variety of activities on the audit days.</p> <p>The planner sighted included gentle chair exercises, aromatherapy, story reading, social van rides, sensory relaxation, bowls, movie sessions, 'blokes' lunch and drinks, line dancing, and knitting and crafts. The planned activities and community connections are suitable for the residents. Residents' were seen engaging in activities during audit. This includes YPD residents who are encouraged to attend activities of interest at the service and in the community (depending on the National Covid-19 alert levels in place at the time). Activity progress notes participation records are completed daily. Residents' meetings were conducted monthly and progress notes were completed.</p> <p>Three of the six resident files reviewed did not have activities care</p>

		plans in place and three were overdue for review.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is documented on each shift by care staff and the nursing team in the progress notes. All noted changes by the caregivers are reviewed by the nursing team and interventions initiated promptly.</p> <p>Each resident's care plan and interRAI assessments are evaluated, reviewed, and amended either when clinically indicated by a change in the resident's condition or at least every six months whichever is earlier. The exceptions are included in the area for improvement raised in 1.3.3.3. The evaluations sighted reflected the achievement of the set goals over the previous six months. The evaluations are carried out by the RNs in conjunction with family members, residents, the GP, and specialist service providers. However, some residents' files sampled had no completed activities care plans in place or activities related reviews were overdue (refer 1.3.7.1).</p> <p>Where progress is different from expected, the service responded by initiating changes to the care plan. Short-term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whānau are included and informed of all 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>	FA	<p>Residents and family/whānau are supported to access or seek a referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP and the nursing team refer to specialist service providers and the DHB. Referrals are followed up regularly by the GP, CNL, and RNs. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Acute or urgent referrals are attended to, and the resident is transferred to the public hospital in an ambulance if required.</p>



<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious / hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and provide relevant education and training for staff. Waste is also managed by an external contracted company, with the exception of recycling which is undertaken by the Auckland City Council. Material data sheets were readily available where chemicals are used and stored, and staff interviewed knew what to do should any chemical spill/event occur. Certificates detailing applicable staff recent and historic training were sighted.</p> <p>There is appropriate supplies of personal protective clothing and equipment available, and staff were observed using this appropriately.</p> <p>A contractor provides ongoing pest control services.</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>The facility has two levels. All residents care areas are on the ground (main) floor. The upper level is used by staff only.</p> <p>The building warrant of fitness (expiry date 16 March 2022) was displayed in the main entrance. Appropriate systems are in place to ensure the residents` physical environment and facilities are fit for their purpose and are maintained. Maintenance requests are actioned in a timely manner as per request records sighted. The testing and tagging of electrical equipment and calibration of bio medical equipment was current and confirmed in documentation reviewed, interviews with maintenance personal and observation of the environment. The environment was hazard free, residents were safe, and independence promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and settings. Four residents have their own deck area outside their bedroom.</p> <p>Residents are happy the facility is maintained and homely. There is ongoing renovation occurring as residents` rooms become vacant, with another room recently completed.</p>

		Prospective Owner: The prospective owner is not aware of any issues or risks related to the land, building or equipment. However, as part of due diligence, an independent building inspection was scheduled to occur within 48 hours of the audit. There are no plans to change the facility or type of services provided on site. The ongoing renovation of rooms will continue as able.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Hand basins are present in sampled residents' bedroom There are adequate numbers of accessible communal showers and toilet facilities throughout the facility including designated staff and visitor toilets. There is one ensuite that is shared by residents from two rooms. There are occupied/vacant signs for use in bathroom and toilet areas. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<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>Twenty-six residents' bedrooms are single occupancy, and two bedrooms are share twin. One room currently has two residents. The facility manager discussed the process of admitting a resident to a shared room to ensure this was appropriate and the rights of both residents were met. The rooms all contained space for the residents' personal possessions, and use of mobility devices, if required. Residents were sighted mobilising inside the care home independently, including while using a mobility aid.</p> <p>The staff interviewed advised there is sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this.</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</p>	FA	<p>Most residents have single occupancy rooms. There are a number of other areas that residents can use for activities or to meet with family and friends. This includes the lounge and dining rooms, and the external / garden and deck areas. The residents and family members interviewed confirmed that there was sufficient space available for</p>

needs.		residents and support persons to use if required in addition to the residents' bedrooms
<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>Policies detail how the cleaning and laundry services are to be provided. Laundry services are contracted to an off-site commercial laundry. This includes the washing of residents' personal clothing. Residents' personal clothing is washed, folded and returned. Staff check the name on the garment on return and distribute to the correct resident.</p> <p>The residents and family members interviewed confirmed the rest home is kept clean and tidy. Audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated compliance with the service requirements. Residents and family members interviewed were satisfied the care home was kept clean and tidy and raised no concerns about the laundry services.</p> <p>Chemicals are stored in designated secure cupboards / rooms which are locked. A cleaner identified being provided with training on the safe handling of chemicals, and had written instructions readily available on the use of products and required cleaning processes / activities.</p> <p>Instructions for managing emergency exposures to chemicals was readily available to staff.</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 fire evacuation plan sighted was approved by the New Zealand Fire Service (NZFS) in a letter dated 10 September 2003. Another letter sighted from the NZFS dated 15 April 2015 noted that the alterations to the building did not require any changes to the evacuation scheme / plan currently in place.</p> <p>The most recent fire evacuation education was conducted in November 2021 as part of the internal staff education programme. In lieu of the external fire safety consultant coming on site (due to the national Covid-19 alert levels in place), the facility manager discussed the fire evacuation processes with staff and provided all staff with a copy of the evacuation plan. The facility manager has contacted the fire safety</p>

		<p>consultant to reschedule a fire evacuation drill for as soon as possible and is awaiting confirmation of a date.</p> <p>The temperature of hot water is being regularly monitored and is within the required temperature range.</p> <p>Policy documents and a wall mounted flip chart provides guidance for staff on responding to civil emergency and disaster events, and training was last provided in May 2021.</p> <p>Review of the staff files and training records verified that registered nurses have a current first aid certificate. A registered nurse is on site at all times.</p> <p>There are sufficient supplies available of dry food, lighting, torches and batteries, and other clinical supplies for use in an emergency. A portable gas cooker is available along with spare blankets. A 1000 litre water tank is onsite that contained sufficient supplies for use in emergency. The water is treated regularly and changed annually. Other emergency supplies are checked and rotated as required. Staff discussed learnings arising from the July 2021 power outage and an action plan has been documented to address issues.</p> <p>Call bells are present in the bathrooms and residents' bedrooms. They alert via an audible sound, and notification through to a centralised panel. Two call bells tested at random were fully functioning. Other call bells were heard during the audit that were attended to promptly.</p> <p>Visitors entering the building are directed via signage to come to the main entrance. All doors are locked at designated times. An intercom and camera are present at this door to enable staff to identify visitors before granting access. Visitor restrictions have been in place as required by the National Covid-19 alert levels, although are now reoccurring in a planned manner. No concerns were expressed by residents or the family members interviewed about security arrangements. Caregivers advise they are required to visually check each resident at night and lock the doors / windows at 7pm and again on shift handover to the night staff. Caregivers advised regular checks of residents is undertaken throughout each shift.</p>
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<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>	<p>FA</p>	<p>All residents` rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is centralised, provided by under-floor heating in the hallways with ducting throughout the facility. The temperature can be adjusted. In the main communal dining room, there is large gas wall mounted heater which effectively warms the room and nearby areas.</p> <p>The facility was warm and well ventilated throughout the audit and residents and families confirmed the facilities were maintained at a comfortable temperature.</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>	<p>FA</p>	<p>The service has a documented infection prevention and control programme that is reviewed annually. The review of the programme is completed by the CNL who is the infection prevention and control coordinator (ICC). A position description for the ICC was in place.</p> <p>The service has guidelines in place to manage and prevent exposure to infections. Infection prevention and control training is provided to staff, residents, and visitors. There were adequate supplies of personal protective equipment (PPE) and hand sanitizers in stock. Hand washing audits were completed as per schedule. Policies and procedures are documented and reviewed regularly. Staff are advised not to attend work if they are unwell or self-isolate and get tested if they have been in contact with a person who has tested positive for Covid-19. All residents were double vaccinated and have also received a booster dose for Covid-19 and have had the influenza vaccine as well. Completed records were sighted in all files sampled.</p> <p>There was a pandemic outbreak plan in place. Information and resources to support staff in managing COVID-19 were regularly updated. Visitor screening and residents` temperature monitoring records depending on alert levels by the MOH were documented.</p> <p>There was a staff member who tested positive for Covid-19 during routine asymptomatic surveillance testing in November 2021. This infection incident was managed according to the policy with help from the local district health board. The affected staff member was isolated as per MOH guidelines. The facility was closed to the public, with GPs,</p>

		<p>family/whanau, residents, and DHB notified. All other staff and residents tested negative throughout the entire episode of the outbreak management plan. The tests included use of rapid antigen tests and weekly polymerase chain reaction (PCA) tests. Additional staff resource was provided by the local district health board. Documented evidence of staff and residents' tests and the management process were sighted.</p> <p>Prospective Provider: The prospective owner and their new facility manager advise the existing infection prevention and control policies and procedures, and the surveillance programme will continue as currently occurring.</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>There is a designated person who is responsible for implementing the infection control programme. The ICC indicated there are adequate people, physical, and information resources to implement the programme. Infection control reports are completed monthly, and these are discussed at management and staff meetings. Staff confirmed that infection rates information is shared promptly.</p> <p>The ICC has access to residents' infection control data collected within the organisation and reported that there are sufficient resources and systems to collect all the necessary information. Surveillance, internal audits, and investigations, and corrective actions are completed as required.</p> <p>Specialist support can be accessed through the district health board, the medical laboratory, external consultants, and the attending GPs. The FM and executive director advised the DHB was very supportive during the recent Covid -19 episode.</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</p>	FA	<p>The service has documented policies and procedures in place that reflected current best practices. Policies and procedures are accessible and available for staff in the nurses' station, and these are in electronic form or paper-based. The policies were current and last reviewed in January 2021 and are noted as due for next review in 2025.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed</p>

<p>type of service provided.</p>		<p>following organisational policies, such as appropriate use of hand sanitisers, good hand washing technique, and use of disposable aprons and gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures.</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>	<p>FA</p>	<p>Staff training on infection prevention and control is provided on an ongoing basis including during orientation, at shift handovers, at staff meetings and are included in the annual in-service education programme. The in-service education is conducted by either the ICC, local laboratory, or other external consultants. Daily 'Zoom' infection control meetings after the positive covid incident were conducted by the local district health board. Regular support was continuously being provided by the local district health board, as confirmed by staff and managers interviewed.</p> <p>The infection training includes handwashing procedures, 'donning and doffing' protective equipment, and regular Covid-19 updates. Records of staff education were maintained. The CNL completed infection prevention and control training online in February 2021.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance programme is defined and appropriate to the size and scope of the service. The ICC collects infections surveillance data, analyses trends, monitors, reviews, and where possible implements corrective action plans to prevent recurrences. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings and at management meetings. Evidence of completed infection control audits, monthly reports, and annual reports was sighted.</p> <p>All staff interviewed confirmed that they are informed of infection rates as they occur. The GPs were informed on time when a resident had an infection and appropriate antibiotics were prescribed for all diagnosed infections.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical nurse leader/restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities involved.</p> <p>On the day of the audit, three residents, all receiving hospital level care, were using a restraint. Lap belt and bedside rails were the forms of restraint in use. No enablers were in use. Enablers are the least restrictive and are only used voluntarily at a resident's request.</p> <p>Restraint is used as a last resort when alternatives have been explored. This was evident on review of records reviewed, and from interviews with staff and managers.</p> <p>Prospective provider: The intended facility manager advised being aware of these standards and is committed to ensuring the use of restraint is minimised and safe.</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>	<p>FA</p>	<p>The restraint approval process involves a registered nurse, a general practitioner, the clinical nurse leader/restraint coordinator, and a family/resident representative, who are responsible for the approval of the use of restraints.</p> <p>A review of residents' records and interviews with a registered nurse and other staff confirmed that there were clear lines of accountability and that all restraints currently in use have been approved. The overall use of restraints is being monitored and reported monthly at staff meetings.</p> <p>Evidence of family/whanau/EPOA involvement in the decision making was on record in the two applicable residents' records sampled. Use of a restraint was also included in the resident's individualised plan of care.</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>Assessments for the use of restraint were documented and included all requirements of the Standard. The registered nurse undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whanau/EPOA. A family member interviewed confirmed their involvement. The individual resident's general practitioner is involved in the final decision on the safety of the use of the restraint.</p> <p>The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and any associated risks. The stated outcome was to ensure the resident's safety and security. Completed assessments were sighted in the two applicable residents' sampled records.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is minimised as much as possible, and a registered nurse and caregivers discussed how alternatives to restraints are discussed and implemented with staff and family members, including the use of sensor mats and/or low beds. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. There was evidence of regular monitoring. Any adverse events/incidents are reported and followed up via the incident reporting system and included in the interRAI re-assessments and care plan process.</p> <p>Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register is maintained by the clinical nurse leader, updated as required, and reviewed/discussed at each monthly staff meeting. The register was reviewed and detailed all residents currently using a restraint.</p> <p>Staff received training in the organisation's policy and procedures and restraint minimisation practices most recently in November 2021.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' records showed that the individual use of restraints is reviewed and evaluated during the care plan and interRAI reviews, three-monthly restraint evaluations and at staff meetings.</p>

		Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	<p>The clinical nurse leader/restraint coordinator undertakes a three-monthly review of each resident with restraint use, most recently at the end of September 2021, and an annual restraint audit (last completed 2 October 2021). These processes included the restraint used and type, whether all alternatives to restraint have been considered, the effectiveness of the restraint use, and the competency of staff, the appropriateness of restraint/enabler education and any feedback from the doctor, staff and families.</p> <p>Any changes to policies, guidelines, staff education/training and processes are implemented if indicated. Data reviewed, minutes and interview with the restraint coordinator confirmed that minimisation of the use of restraint is a priority/focus.</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 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	PA Low	<p>The service is currently managed by a facility manager (FM) who was appointed to the role in July 2017. The FM is a registered nurse, but no longer maintains a current annual practising certificate. This person is experienced in business and marketing management. The FM is supported by a clinical nurse leader who is an experienced registered nurse, and who has worked at this facility for over twenty years and in this current role for twelve years. Their responsibilities and accountabilities are defined in the job descriptions and individual employment agreements reviewed. The FM interviewed confirmed knowledge of the sector, regulatory and reporting requirements. However, due to the impact of Covid-19 restrictions, they have not attended the</p>	<p>Records are not available to demonstrate the current facility manager has completed eight hours of education in the last 12 months related to managing an aged related residential care facility as required to meet the ARRC contract. This is due to the Covid-19 situation.</p> <p>While the prospective owner already owns an aged related residential care facility, and has done so for some years, they stated they have limited knowledge of ARRC contract requirements as responsibilities to date have been delegated to the facility manager (FM).</p>	<p>Ensure the prospective owner has sufficient knowledge of the aged related residential care contract requirements to enable good governance.</p> <p>Ensure the facility manager attends at least eight of hours of education related to managing an ARRC service every 12 months.</p> <p>30 days</p>

		<p>required eight hours of education in the last 12 months as required by the aged related residential care (ARCC) contract. The current owner/executive director has worked in the aged care settings for many years has held governance roles in both the DHB and aged related care settings. The current facility manager will retire following the orientation of the intended new facility manager.</p> <p>Prospective provider:</p> <p>The prospective owner works has worked as a medical practitioner in the health sector for over 13 years and already owns another aged related residential care facility in Auckland. This initial care home was purchased in 2016 and has 35 beds providing both rest home and hospital level care. The prospective owner stated they had limited knowledge of the ARRC contract requirements delegating responsibilities to the full-time facility manager currently working in their existing care home. The transition plan is to have this facility manager and an administrator working across both care homes. The facility manager has worked for the prospective owner for approximately 12 months and is an experienced aged care nurse, with a current annual practising certificate, having worked in senior clinical management and leadership roles.</p> <p>The intended owner has established the company that Papatoetoe Residential Care will be operating within, and has a building inspection scheduled for later in the week of the audit as part of due</p>		
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		<p>diligence. The intended arrangements include the purchase of both the care home services and the land and buildings. The current owner / executive director has informed the DHB portfolio manager of the intended sale. The prospective owner stated they had advised the Ministry of Health.</p> <p>The intended new facility manager was interviewed and confirms being aware of the ARRC contract requirements, and the care planning and service delivery requirements for the sector. The intended new facility manager is satisfied that due to the combined size of both care homes being a total of 65 beds that one facility manager across both sites is suitable and confirmed their intent to continue in the dual facility manager role. A clinical nurse leader will oversee the clinical needs of residents in each care home, with the prospective owner planning to offer this position to the current Papatoetoe Residential Care clinical nurse leader (CNL). The prospective owner has documented an organisation structure with the key responsibilities for the facility manager, clinical nurse leader(s) and the administrator roles summarised. All other roles including recreation/activities, care giving, catering, maintenance and cleaning will continue to be individual care home specific.</p> <p>Another document notes a transition plan which is reported to be 'a living document', and this was seen to be the case as changes were made to the plan both during and subsequent to the audit,</p>		
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		strengthening the transition process. The existing owner / executive director will be available for assistance for at least three weeks to assist the prospective new director/owner and the new FM during the transition/orientation period, and will subsequently be available in an advisory capacity. The current FM will continue for two weeks post change of ownership to help orientate the new FM to the service. The transition plan notes the prospective owner will meet with the residents, staff, family and the DHB prior to possession date, and staff will have job descriptions accompanied by a task list and new employment agreements.		
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	<p>PA</p> <p>Moderate</p>	<p>An essential notification was made in December 2021. The executive director and the facility manager can verbalise the type of events that require notification, and to whom. However, two examples were sighted of events that occurred in 2021 that have not been reported as required including registered nurse shift patterns/staffing challenges (refer to 1.2.8.1), and an unplanned loss of power for 14 and a half hours on 10 July 2021 following a local tornado (refer to 1.4.7). The executive director stated that the DHB portfolio manager was advised of the RN rostering issues and discussed the intended solution prior to these arrangements being implemented. The management team advised there have been no events requiring reporting to the coroner.</p>	<p>Essential notifications have not occurred in relation to the RNs working 24 hour shifts to cover services (refer to 1.2.8.1), and for a power outage that occurred in July 2021.</p>	<p>Ensure that essential notifications are made in a timely manner for all applicable events.</p> <p>90 days</p>

<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>The facility manager works four days on site. The CNL is working additional hours as detailed below.</p> <p>Staff work set rostered shifts and are available to cover any planned or unplanned absences. The facility manager monitors the hours care staff are working.</p> <p>There have been some challenges with registered nurse rostering since mid-August 2021 due to a variety of reasons. This included an RN resignation, bureau staff being booked but not turning up for confirmed shifts or calling in sick with minimal notice resulting in challenges for the employed RNs covering the shifts, Covid-19 precautions, and illness / injury. As a result, a decision was made in collaboration with the two other registered nurses that each RN would work a 24 hour shift on site then have one or two days off. The RN would start work at 7 am and would stay awake until after completing the initial checks with the night caregivers then would have short sleeps on site as able overnight. The caregivers were provided with instructions of what concerns were to be brought to the RN's immediate attention. The night caregivers completed medicine competency assessment requirements. The RNs/CNL advised they preferred this 24 hour shift option rather than having to make ongoing changes to their work and personal schedules to cover. An additional (second) caregiver was rostered onto the night shift to assist. The caregivers stated there were</p>	<p>Due to several factors, there have been difficulties covering the registered nurse roster. While there is an RN on site at all times, the RNs are currently working a 24 shift with sleep periods overnight as able. The service is awaiting the arrival of a fourth RN who has been recruited from overseas, commencing orientation at the end of December 2021.</p>	<p>Ensure safe rostering of registered nurses occurs and ARRC contract requirements are met.</p> <p>60 days</p>
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		<p>no issues accessing the RNs when there was a clinical need and all staff noted these unique circumstances were working very well, with staff working together to meet residents' needs.</p> <p>Prior to and throughout this period, the management team have continued recruitment activities for registered nurses. An overseas RN starts orientating as per the roster on 29 December 2021. This RN has been supported through the process obtaining an appropriate visa and obtaining a place in managed isolation and quarantine (MIQ) facilities. The new RN has recently arrived in New Zealand and has a current APC. The management team have obtained a rental property for this RN and are in the process of equipping it. The managers advised the recruitment of one additional RN would be ideal, with recruitment ongoing. There are no other staff vacancies.</p> <p>A review of sampled residents' records verified residents are receiving the required care. Changes in residents' condition are being identified and followed up appropriately. (Refer to part three of this standard). There has been no significant change in the number of accidents and incidents reported in the three months data sighted (refer to 1.2.4).</p> <p>The DHB provided some RN assistance recently in partnership with Papatoetoe Residential Care in response to a period of additional challenge.</p> <p>The activities coordinator works weekdays. There are six caregivers working on</p>		
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		<p>morning shift for all or part of the shift. There are four caregivers on afternoon shift working all or part of the shift. There is a minimum of two caregivers and one registered nurse on site at all times.</p> <p>The maintenance person works one day on site and lawn mowing is undertaken by a contractor. There are two cooks and two kitchen hands. A cook and a kitchen hand are on duty every day, each working at least seven and a half hours each day. There are two cleaners employed. A cleaner works six hours each day weekdays and two hours on weekend days. The administrator works weekdays. Laundry services are contracted off site.</p>		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	<p>Medication competencies were completed annually for all RNs administering medicines and also for caregivers checking PRN (as required) medications. A medication competency for one of the RNs was not sighted at the time of the audit. In interview with the RN and FM, they both reported that this was only partially completed, and records of aspects completed were not available on site.</p>	<p>Records were not available to demonstrate that one of the three RNs had a current medication competency (due September 2021).</p>	<p>Ensure all staff involved with medicine management have current medicine competencies, and appropriate records are available when required.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time</p>	PA Low	<p>All files sampled identified that initial assessments and initial care plans were resident centred, and these were completed within the required time frames. InterRAI assessments were completed within 21 days and based on this assessment and the staff's observation of</p>	<p>Four out of 28 residents' interRAI re-assessments in the interRAI data base were not completed in a timely manner with overdue time frames ranging from 87-190 days.</p>	<p>Ensure all interRAI assessments are completed within timeframes that safely meet the needs of the residents and ARCC</p>

frames that safely meet the needs of the consumer.		<p>the resident. Long-term care plans were also developed.</p> <p>Some of the ongoing interRAI reviews completed did not meet time frames that safely met the needs of the residents. The CNL and RNs confirmed that these overdue assessment reviews were receiving due consideration and the process to complete the review was currently underway.</p>		<p>contract requirements.</p> <p>90 days</p>
<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>	<p>PA Moderate</p>	<p>The planned activities are meaningful to the residents and their needs and abilities. The activities are based on assessments and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments.</p> <p>The activities coordinator and RN reported that residents' activities care plans were evaluated every six months or when there was any significant change; however, some were not reviewed nor developed in a timely manner. The activities plans for three out of six sampled residents were overdue for review. Last reviewed between December 2020 and March 2021. An individualised activities plan had not been documented for three sampled residents. However, family members and residents reported overall satisfaction with the level and variety of activities provided.</p>	<p>Three out of six residents' files sampled did not have individualised activities care plans in place. (ii) Three out of six residents' files sampled had activities care plans that were overdue for review.</p>	<p>Develop and review the residents' activities plan in a timely manner.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.