

Pacific Haven (2015) Limited - Pacific Haven Residential Care

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to Manatū Hauora (the Ministry of Health).

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Pacific Haven Residential Care (2015) Limited	
Premises audited:	Pacific Haven Residential Care	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 8 February 2024	End date: 9 February 2024
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:	28	

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 sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou motika | our rights
- hunga mahi me te hanganga | workforce and structure
- ngā huarahi ki te oranga | pathways to wellbeing
- te aro ki te tangata me te taiao haumarū | person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita | infection prevention and antimicrobial stewardship
- here taratahi | restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. 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 subsections applicable to this service fully attained with some subsections exceeded
	No short falls	Subsections 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 subsections 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 subsections 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 subsections applicable to this service unattained and of moderate or high risk

General overview of the audit

Pacific Haven is located in Christchurch. The service is certified to provide rest home level care for up to 30 residents. There were 28 residents on the days of the audit. The clinical nurse manager oversees the clinical operations of the care centre and is supported by an operations manager and experienced owner manager (registered nurse).

This surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Services Standard and the services contract with Te Whatu Ora Health New Zealand – Waitaha Canterbury. The audit process included a review of quality systems, the review of residents and staff files, observations, and interviews with residents, family/whānau, staff, management, and a general practitioner.

The facility is one of two aged care facilities owned by the experienced husband/wife team. Feedback from residents and family/whānau was very positive about the care and the services provided. An orientation programme is in place to provide staff with appropriate knowledge and skills to deliver care.

The service has addressed the three previous partial attainments relating to communication, progress notes, and the environment.

This surveillance audit identified shortfalls related to consents; implementation of the quality programme; training; care plan interventions; monitoring of wounds; care plan evaluations; medication management; and aspects of infection control.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.

Some subsections applicable to this service partially attained and of low risk.

The service provides an environment that supports residents' rights, and culturally safe care. Details relating to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers Rights (the Code) is included in the information packs given to new or potential residents and family/whānau. A Pacific health and wellbeing action plan (Ola Manuia) is in place.

Residents and family/whānau interviewed confirmed that they are treated with dignity and respect. There was no evidence of abuse, neglect, or discrimination. There is an established system for the management of complaints that meets guidelines established by the Health and Disability Commissioner.

Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.

Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The service is privately owned by two owners. The service has an annual business and quality plan documented. Hazards are identified with appropriate interventions implemented.

A recruitment and orientation procedure is established. Caregivers are buddied with more experienced staff during their orientation. There is a staffing and rostering policy. Staffing levels and skill mix meet the cultural and clinical needs of residents. Workforce planning is fair and equitable.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	--	--

The clinical nurse manager and owner/RN are responsible for the assessment, development, and evaluation of care plans. Care plans demonstrate input from residents and family/whānau.

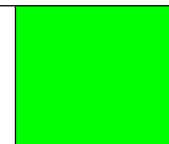
The organisation uses an electronic medicine management system for e-prescribing, and administration of medications. The general practitioner is responsible for all medication reviews. Staff involved in medication administration are assessed as competent to do so.

The food service caters for residents' specific dietary likes and dislikes.

Residents are referred or transferred to other health services as required.

Te aro ki te tangata me te taiao haumaruru | Person-centred and safe environment

Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.

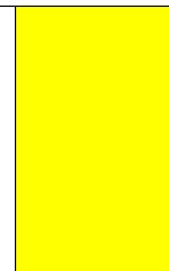


Subsections applicable to this service fully attained.

There is a current building warrant of fitness. There is a planned and reactive maintenance programme in place.

Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

Includes five subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.

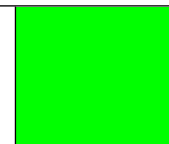


Some subsections applicable to this service partially attained and of low risk.

An infection control programme is documented for the service. There have been no outbreaks since the previous certification audit in 2022.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.



Subsections applicable to this service fully attained.

The service is restraint free. Policies and procedures document that Pacific Haven is committed to a restraint-free environment, led by the clinical nurse manager, with support from the owners.

Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	11	0	4	4	0	0
Criteria	0	38	0	6	7	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)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Ngā paerewa Health and disability services standard

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

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

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	FA	<p>There is a documented commitment to recognising and celebrating tāngata whenua in a meaningful way through partnerships, educational programmes, and employment opportunities. The Māori health plan acknowledges Te Tiriti o Waitangi as a founding document for New Zealand and the provision of services based on the principles of mana motuhake. Residents are involved in providing input into their care planning, their activities, and their dietary needs. Staff have completed cultural safety competencies annually; however, there has been no training on Te Tiriti o Waitangi since 2021 (link 2.3.4).</p>
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific</p>	FA	<p>Pacific Haven has a policy based on the Pacific Health and Wellbeing Plan (Ola Manuia) 2020-2025 that encompasses the needs of Pasifika and addresses the Ngā Paerewa Health and Disability Services Standard. The aim is to uphold the principles of Pacific people by acknowledging respectful relationships and embracing cultural and spiritual beliefs and providing high quality healthcare. Cultural competencies included recognition of Pacific peoples. There were staff who identified as Pasifika employed at the facility, who assist in the implementation of the Pacific health plan.</p>

peoples for improved health outcomes.		
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>Four residents interviewed and two family/whānau reported that all staff respected their rights, and that they were supported to know and understand their rights. Care plans reviewed were resident centred and evidenced input into their care and choice/independence. The Code of Rights is displayed in English and te reo Māori. Staff last completed training on the Code of Rights in 2021 (link 2.3.4). Interviews with four staff (two caregivers, one cook and one housekeeper), two managers (one operations manager and one owner manager/RN) described ways they uphold residents rights in relation to their role.</p>
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	FA	<p>The abuse and neglect policy is being implemented. Pacific Haven Village policies prevent any form of discrimination, coercion, harassment, or any other exploitation. A comprehensive code of conduct is discussed and signed by staff during their induction to the service. The code of conduct addresses harassment, racism, and bullying. Staff sign to acknowledge that they accept the code of conduct as part of the employment process.</p> <p>Staff complete education during orientation on how to identify abuse and neglect; however, training has not been provided over the previous two years (link 2.3.4). Staff are encouraged to value the older person, showing them respect and dignity. All residents and families/whānau interviewed confirmed that the staff are very caring, supportive, and respectful. The service implements a process to manage residents' comfort funds, such as sundry expenses.</p> <p>Professional boundaries are defined in job descriptions. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation.</p>
<p>Subsection 1.6: Effective communication occurs</p> <p>The people: I feel listened to and that what I say is valued,</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints, and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accident/incident forms have a</p>

<p>and I feel that all information exchanged contributes to enhancing my wellbeing.</p> <p>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.</p> <p>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.</p>		<p>section to indicate if next of kin have been informed (or not) of an adverse event. Review of incident forms evidenced families/whānau who wish to be notified of adverse events, are informed in a timely manner. The operations manager maintains a next of kin contact list which identifies family/whānau availability and their wishes regarding information related to adverse events. The previous partial attainment (#1.6.2) has been addressed.</p> <p>Family/whānau interviewed stated that they are kept informed when their family member's health status changes or if there has been an adverse event.</p>
<p>Subsection 1.7: I am informed and able to make choices</p> <p>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p> <p>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.</p>	PA Low	<p>There are policies documented around informed consent. Informed consent processes were discussed with residents and family/whānau on admission. Five electronic resident files were reviewed and evidenced general consents were included in files as part of the admission process. Consents included outings, photographs, release of medical information, medication management and medical cares; however, not all consents on file were signed. Specific consent forms had been signed by residents or their activated enduring power of attorney (EPOA) for procedures such as vaccines and other clinical procedures.</p>
<p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p> <p>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or</p>	FA	<p>The complaints procedure is equitable and is provided to residents and family/whānau on entry to the service. The clinical nurse manager maintains a record of all complaints, both verbal and written, by using a complaint register. There have been no complaints since the previous audit in August 2022. The complaint forms are available in the facility, along with information on advocacy should they require this.</p> <p>Residents and family/whānau interviewed understood their right to make a complaint, knew how to do so, and stated they are able to raise any</p>

<p>escalate complaints in a manner that leads to quality improvement.</p>		<p>concerns and provide feedback on services. Staff were able to describe the complaints process.</p> <p>On interview, the owner/RN and operations manager were familiar with the complaint management process. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. The owner/RN, operations manager and clinical staff acknowledged the understanding that for many Māori, there is a preference for face-to-face communication and confirmed their commitment to do this wherever possible. On interview, residents and family/whānau stated they felt comfortable to raise issues of concern with management at any time.</p>
<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>PA Low</p>	<p>Pacific Haven, located in South Brighton, Christchurch, provides rest home level of care for up to 30 residents. On the days of the audit, there were 28 residents. One resident was on a younger person with a disability (YPD) contract; five were on long-term support – chronic health conditions (LTS-CHC) contracts; three residents were on respite contracts; one resident on an accident corporation contract (ACC); and one resident was a boarder. The remaining 17 residents were under the age-related residential care contract (ARRC). There are no double or shared rooms.</p> <p>The facility was purchased in 2015 by two directors (owners). The owners also own one other aged care facility and were knowledgeable around the contractual and legislative requirements. One owner is known as the facility manager and is based at Pacific Haven. He is responsible for building maintenance. The second owner is based at the sister facility and is a registered nurse (RN) with a current practising certificate. The owner/RN covers during the absence of the clinical nurse manager (CNM). The owner/RN interviewed confirmed that they have undertaken cultural training and can demonstrate expertise in Te Tiriti, health equity, and cultural safety. The identification of barriers with implemented strategies are identified in the business plan, quality plan and Māori health plan. Collaboration with staff and whānau who identify as Māori and/or tāngata whaikaha reflect their input for the provision of equitable delivery of care. One of the owners (the facility manager) is able to converse in te reo Māori and maintains a close relationship with kaumātua. The CNM and the operations manager work Monday to Friday. The CNM was on leave on the days of audit and the owner/RN was on site to manage clinical cares. The</p>

		<p>owners have on site or telephone communication with the operations manager and CNM at Pacific Haven on a daily basis and meet at least fortnightly.</p> <p>Quality goals are listed in the 2023 business plan and have been carried over to 2024. The combined business and quality plan was reviewed in January 2024 and all goals were carried over to 2024. The quality goals include monitoring of survey results, internal audits, infections, and adverse events, with an emphasis on introducing an online education system for staff and uploading of all resident documentation to the electronic system. The business and quality goals state monitoring will involve the CNM, operations manager and owners; however, review of these goals are not evidenced as occurring as planned. The owner/RN interviewed stated the team meet at least fortnightly to review goals; however, acknowledged there was no documentation to support this. Clinical governance is the responsibility of the CNM and owner/RN. This includes (but is not limited to) the review of clinical risk.</p> <p>Both owners regularly attend aged care conferences. The operations manager confirmed eight hours of professional development per year relating to their role and responsibilities. Day-to-day operations are the responsibility of the operations manager, who has been in her role for two and a half years, and the CNM who has been in her role at Pacific Haven for the same time period. The operations manager was previously the administrator and a caregiver and has worked at Pacific Haven for six years. The CNM has worked in aged care for over four years.</p>
<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and</p>	<p>PA Moderate</p>	<p>Pacific Haven has documented quality and risk management programme, developed by an external contractor. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. Policies are regularly reviewed and have been updated to align with the Ngā Paerewa 2021 Standard. A document control system is in place. The operations manager advised on interview that new policies or changes to policy are communicated to staff at handovers. This was confirmed by staff.</p> <p>Key operational concerns and data including (but not limited to) occupancy;</p>

<p>these systems meet the needs of people using the services and our health care and support workers.</p>	<p>discharges; complaints; Section 31 reports; staffing; health and safety; and property issues are shared verbally on a daily basis with the owners. Quality data is not evidenced as being reported and links to the organisation's strategic objectives is not evidenced. Clinical data is entered into the electronic system, including infections and adverse events; however, these have not been analysed, reported or shared with staff throughout 2023. On interview, staff were unaware of quality data indicator results.</p> <p>There is an annual quality programme calendar which includes schedules of training, meetings, and internal audit requirements for each month. There is minimal documentation to evidence implementation of the quality programme since July/August 2022. The documented internal audit schedule has not been fully implemented for 2023. Where audits were completed, there has been 100 percent compliance and corrective actions have not been required. On interview, management confirmed corrective actions are implemented where indicated to address service improvements; however, these have not always been documented. Meetings are not evidenced as being held as scheduled, and documented minutes of resident, family/whanau, staff or quality meetings being held in 2023 could not be located.</p> <p>A health and safety system is in place with annual identified health and safety goals. The operations manager has recently been appointed as the health and safety officer and is scheduled to complete formal health and safety training in April 2023. Manufacturer safety datasheets are up to date. Hazard identification forms and an up-to-date hazard register had been reviewed in December 2023 (sighted). A staff noticeboard in the nurses' station keeps staff informed on health and safety. Staff and external contractors are orientated to the health and safety programme. Manual handling competencies are completed annually. In the event of a staff accident or incident, a debrief process is documented on the electronic accident/incident form.</p> <p>Electronic reports on the resident management system are completed for each incident/accident, with immediate action noted and any follow-up action(s) required; however, opportunities to minimise future risks were not consistently identified on the reports reviewed.</p> <p>The November 2023 annual resident and family/whānau satisfaction surveys have been correlated, but not yet analysed or communicated to</p>
---	--

		<p>residents and family/whānau. The results indicate that areas for improvement include knowledge of the complaints process, communication and facility odours. Results will be shared in the next staff, resident and family/whānau meetings, as confirmed on interview with management.</p> <p>Discussions with the owners evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been six Section 31 notifications completed for residents absconding. There have been no outbreaks since the previous audit. Management described outbreak management, notifications and staff debriefs.</p>
<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	<p>PA Moderate</p>	<p>The staffing policy meets with the safe staffing hours and aligns with the ARRC contract with Te Whatu Ora – Waitaha Canterbury. The clinical nurse manager is rostered 40 hours a week, with additional support from the owner/RN. All staff hold current first aid certificates, ensuring a first aid trained staff member on duty 24/7. Interviews with residents and families/whānau confirmed staffing overall was satisfactory.</p> <p>There is no documented annual education and training schedule, and training has not been fully implemented since August 2022. However, a quality improvement initiative for 2024 is documented to introduce training via an online platform.</p> <p>Competencies are completed by all staff annually. Staff completed competency assessments as part of their orientation (including fire safety; hand hygiene; falls prevention; communication; personal cares; restraint; challenging behaviours; infection control; personal protective equipment; manual handling; and health and safety). All caregivers are required to complete annual competencies for medication administration, restraint; handwashing; correct use of personal protective equipment (PPE); medication; blood sugar levels and insulin administration; cultural safety; and moving and handling. A record of completion is maintained in staff files and on a paper-based system maintained by the operations manager.</p> <p>The service supports and encourages caregivers to obtain a New Zealand Qualification Authority (NZQA) qualification. Out of a total of eight caregivers, two have completed level four NZQA qualification, three have completed their level two NZQA qualification, and one caregiver has completed level one. The operations manager is a Careerforce assessor</p>

		<p>and actively works with caregivers to attain qualifications.</p> <p>Registered nurse specific wound training is available through Te Whatu Ora – Waitaha Canterbury and palliative care through Nurse Maude. The CNM and the owner manager (RN) are interRAI trained. The CNM is the infection control coordinator and has not completed education on infection control during the previous 12 months.</p>
<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	FA	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Staff files are stored securely. Five staff files reviewed evidenced implementation of the recruitment process, employment contracts, police checking, and completed orientation programmes specific to their roles.</p> <p>There are job descriptions in place for all positions that include outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. All staff sign their job description during their onboarding to the service.</p> <p>A register of practising certificates is maintained for all health professionals. The appraisal policy is implemented, and all staff who had been employed for over one year have an annual appraisal completed.</p> <p>The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation and are repeated annually. The service demonstrates that the orientation programmes support staff to provide a culturally safe environment for Māori.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p>	PA Moderate	<p>Five resident files were reviewed, including one resident on a LTS-CHC contract, one resident on respite, one resident funded by ACC, and one resident on a YPD contract. The CNM is responsible for conducting all assessments and for the development of care plans. There is evidence of resident and family/whānau involvement in the interRAI assessments and long-term care plans reviewed and this is documented in progress notes. Family/whānau interviewed stated they are involved in the development</p>

<p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>and evaluation of the care plan.</p> <p>All residents have admission assessment information collected and an initial care plan completed at the time of admission. The file of the resident funded under the ARRC contract had interRAI assessments and all residents had a comprehensive suite of paper-based assessments, including cultural assessments completed within three weeks of admission. InterRAI reassessments had been developed within the required timeframes in all files reviewed. Cultural assessments included identification of traditional healing practices, where applicable. The owner/RN interviewed describe working in partnership with the resident and family/whānau to develop the initial care plan and long-term care plan.</p> <p>The long-term care plan aligns with the service's model of person-centred care; however, it did not always reflect all of the resident's assessed needs.</p> <p>All residents had been assessed by the general practitioner (GP) within five working days of admission. There is a general practitioner (GP) from a local medical practice who visits visit monthly and provides out of hours cover. The GP reviews residents at least three-monthly. The CNM or owners also provide support and advice when needed after hours. Specialist referrals are initiated as needed. Allied health interventions were documented; however, they were not always integrated into care plans. The service has a physiotherapist available as required. A podiatrist visits regularly and a dietitian, speech language therapist, and wound care specialist nurse is available as required through Te Whatu Ora – Waitaha Canterbury.</p> <p>Evaluations were not always completed six-monthly or sooner for a change in health condition. Written evaluations reviewed did not identify if the resident's goals had been met or unmet. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. When there is a change in resident health needs, such as infections, wounds, or recent falls, appropriate assessments are completed and short-term care plans initiated. Short-term care plans did not always evidence regular evaluations and timely transfer to the long-term care plans.</p> <p>Caregivers interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery; this was sighted on the day of audit and found to be comprehensive in nature. Progress notes are written electronically every shift and as necessary by caregivers and at least weekly by the CNM. The CNM or owner/RN further</p>
--	--

	<p>add to the progress notes if there are any incidents or changes in health status. The previous partial attainment #3.2.5 has been addressed in relation to progress notes; however, care plan evaluations were not always completed six-monthly or sooner for a change in health condition. Written evaluations reviewed did not identify if the resident's goals had been met or unmet. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. When there is a change in resident health needs, such as infections, wounds, or recent falls, appropriate assessments are completed, and short-term care plans initiated. Short-term care plans did not always evidence regular evaluations and timely transfer to the long-term care plans.</p> <p>Incident and accident reports reviewed evidenced timely RN follow up, and family/whanau are notified following adverse events in line with their documented preferences (confirmed in interviews). Neurological observations have been completed as per the falls management policy and neurological observation policy. The previous shortfall #3.2.4 has been addressed in relation to neurological observations; however, not all wound monitoring charts have been maintained. Wound assessments and wound management plans were not documented for one resident with a current wound. An electronic wound register is documented; however, is not maintained. There is access to the Nurse Maude wound nurse specialist. Caregivers and the registered nurses complete monitoring charts, including bowel chart; vital signs; weight; food and fluid chart; blood glucose levels; and behaviour as required.</p> <p>Caregivers interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. Continence products are available and resident files included a continence assessment, with toileting regimes and continence products identified for day use and night use. There is access to a continence specialist as required.</p> <p>Residents interviewed reported their needs and expectations were being met. When a resident's condition alters, the CNM or owner/RN initiates a review with a GP. Family/whānau contact is recorded on the electronic database and includes family notifications and discussions, including evidence to indicate families/whānau are informed following an adverse event where they wish to be informed.</p>
--	---

<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies available for safe medicine management that meet legislative requirements. Staff who administer medications have been assessed for competency on an annual basis. Staff were observed to be safely administering medications. The CNM, owner/RN and caregivers interviewed could describe their role regarding medication administration. The service uses blister packs for all medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. The effectiveness of 'as required' medications is not always recorded in the electronic medication system or in the progress notes.</p> <p>All medications are stored securely in a locked cupboard or in the locked medication trolley in the nurses' station. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. Expired medicines were being returned to the pharmacy promptly. Not all eyedrops and decanted antipsychotic solutions evidenced opening dates.</p> <p>Ten electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three-monthly; however, not all medication charts have photo identification and allergy status identified. Medication expiry dates are checked by registered staff; however, there was evidence of expired medicines which were still in current use. There are no resident's self-administering their medications. The medication competency policy describes the procedure for self-medicating residents, and staff interviewed confirmed this would be implemented if required. There are no standing orders in use.</p> <p>Medication incidents were completed in the event of a drug error and corrective actions were acted upon. A sample of these were reviewed during the audit.</p>
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to</p>	<p>FA</p>	<p>Residents' nutritional requirements are assessed on admission to the service in consultation with the residents and family/whānau. The nutritional assessments identify resident's personal food preferences, allergies, intolerances, any special diets, cultural preferences, and modified texture requirements. Copies of individual dietary preferences were available in the</p>

<p>traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>		<p>kitchen folder. A food control plan is in place and expires in April 2024.</p>
<p>Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.</p>	<p>FA</p>	<p>A standard transfer notification form is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families/whānau were involved in all discharges to and from the service and there was sufficient evidence in the residents' records to confirm this. Records sampled evidenced that the transfer and discharge planning included risk mitigation and current resident's needs. The discharge plan sampled confirmed that, where required, a referral to other allied health providers to ensure the safety of the resident, was completed.</p>
<p>Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>	<p>FA</p>	<p>Appropriate systems are in place to ensure the resident's physical environment and facilities are fit for purpose. There is a proactive and reactive maintenance programme, and buildings, plant, and equipment are maintained to an adequate standard. There is a current building warrant of fitness that expires on 1 April 2024. Toilet and shower repairs have been completed. All toilets and showers have extractor fans installed improving ventilation. The previous partial attainment # 4.1.6 has been addressed. All electrical equipment is tested and tagged, and bio-medical equipment calibrated. Water temperatures were monitored and recorded. Residents and family/whānau interviewed were happy with all aspects of the environment. Spaces were culturally inclusive and suited the needs of the resident groups.</p>
<p>Subsection 5.2: The infection prevention programme and</p>	<p>PA Low</p>	<p>The infection prevention control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles,</p>

<p>implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>		<p>responsibilities and oversight, and the training and education of staff. Policies and procedures are provided by an external consultant with input from infection control specialists and reviewed by the management team and governance. Policies are available to staff and linked to the quality system. Infection control is included in the internal audit schedule; however, these have not been completed as scheduled (link 2.2.2). Any corrective actions identified have been implemented and signed off as resolved. The infection control programme has not been reviewed since 2021. The owners access online reports and receive verbal reports of infection concerns.</p> <p>The infection control policy states that Pacific Haven Village is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan. The infection control coordinator has not undertaken recent education related to infection control (link 2.3.4). The owner manager/RN advised additional support is available from expertise at Te Whatu Ora – Waitaha Canterbury, if required. Staff have completed infection prevention and control associated competencies, such as handwashing and the use of personal protective equipment; however, attendance at infection control or outbreak training is not evidenced (link 2.3.4).</p>
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p>	<p>PA Low</p>	<p>The infection prevention control policy describes surveillance as an integral part of the infection prevention control programme. Monthly infection data is collected for all infections based on signs, symptoms, and the definition of the infection. Infections are entered into the electronic infection register; however, the register has not been maintained and monthly reporting has not been completed (link 2.2.2). The data collated is not evidenced to be monitored and analysed for trends, monthly and annually as per policy, and there was no formal evidence of reporting data to the owners. Pacific Haven Village does not yet incorporate ethnicity data into surveillance methods. Infection control concerns are discussed at staff handovers. Internal infection control audits have not been completed as scheduled (link 2.2.2). Pacific Haven receives regular notifications and alerts from Te Whatu Ora Health – Waitaha Canterbury for any community concerns.</p>

		<p>There have been no outbreaks reported since the previous audit in 2022. The infection prevention coordinator was on leave on the days of audit. The owner/RN and operations manager described appropriate management and notification of outbreaks should they occur.</p>
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>	<p>FA</p>	<p>An interview with the owner/RN who was covering for the restraint coordinator, described the organisation's commitment to restraint minimisation. This is supported by the policies and procedures. On the days of audit there was no restraint in use. The clinical nurse manager is the restraint coordinator (absent during the audit).</p> <p>Staff attend training in behaviours that challenge and de-escalation techniques. During interview, the owner/RN confirmed alternatives to restraint, behaviours that challenge, and residents who are a high falls risk, are discussed at informal meetings with the CNM.</p> <p>A comprehensive assessment, approval, monitoring, and quality review process is documented for all use of restraint. The policy states 'at all times when restraint is considered, the facility will work in partnership with Māori, to promote and ensure services are mana enhancing'. The owner/RN confirmed the kaumātua would be consulted as required if restraint was ever considered.</p>

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our 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 1.7.5</p> <p>I shall give informed consent in accordance with the Code of Health and Disability Services Consumers' Rights and operating policies.</p>	PA Low	On admission, the clinical nurse manager discusses the admission agreement and general consent processes with the resident and/or their families/whānau. All files viewed included consents forms; however, not all consents on file were signed.	Two of five files did not evidence signed consent forms.	<p>Ensure all residents have signed consent forms on file.</p> <p>90 days</p>
<p>Criterion 2.1.4</p> <p>Governance bodies shall evidence leadership and commitment to the quality and risk management system.</p>	PA Low	The combined business and quality plan reflects a commitment to the quality and risk management system. The owner/RN interviewed stated there was ongoing informal monitoring of the quality goals; however, there is minimal documented evidence to support this.	There is a lack of documented evidence to support ongoing review of quality goals by governance and the management team.	<p>Ensure there is documentation to support governance review of quality goals.</p> <p>90 days</p>

<p>Criterion 2.2.2</p> <p>Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.</p>	<p>PA Moderate</p>	<p>The service has a documented quality management framework; however, there was limited evidence the quality and risk framework has been fully implemented for 2023. Internal audits were completed for approximately 25% of the schedule. There was no evidence of meeting minutes to share quality data and corrective actions with staff.</p>	<p>i). Staff meetings, quality meetings and resident, family meetings have not been documented as occurring throughout 2023.</p> <p>ii). Internal audits scheduled for 2023 were not evidenced as occurring as per schedule. Most audits are scheduled two to four times per annum; however, the completed schedule evidences the majority were completed once only. The completed audits included (but not limited to): admission audit; progress notes; care plan and resident file; cultural safety and spiritual beliefs; infection prevention; and antimicrobial stewardship.</p> <p>iii) Corrective actions have not been documented where identified.</p>	<p>i)-(iii). Ensure internal audits are fully implemented and documentation reflects implementation of corrective action plans.</p> <p>60 days</p>
<p>Criterion 2.2.4</p> <p>Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them.</p>	<p>PA Low</p>	<p>The service distributed the survey to 28 residents. Twenty-five were returned. The results identified areas which could be improved around the complaints process, communication, and odour management; however, there is no documented analysis or action plan. Electronic incident forms are completed for all adverse events; however, the section of the form identifying corrective actions or opportunities to minimise future events was not routinely</p>	<p>i). Annual resident and family/whānau satisfaction surveys have been correlated but not yet analysed or an action plan developed.</p> <p>ii). Identification of risks or opportunities to prevent future events are not always documented on incident forms.</p> <p>iii) Clinical data analysis is not shared with staff, as confirmed on interview with caregivers.</p>	<p>i). Ensure annual satisfaction survey results are reviewed by management, opportunities for improvement are identified and a plan to respond is identified.</p> <p>ii). Ensure incident forms identify risks and opportunities to prevent future events.</p> <p>iii). Ensure clinical data</p>

		documented.		analysis is shared with staff. 90 days
<p>Criterion 2.3.4</p> <p>Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.</p>	PA Moderate	<p>A competency schedule is documented and maintained by the operations managers. All staff have evidence of completion of required competencies on file. On interview, the owner/RN had recently become aware mandatory training had not been provided as required. The training and competency schedule has not been documented as implemented since August 2022 and all of 2023. A quality improvement plan is documented to introduce online training for staff training in 2024. The operations manager is committed to documenting and implementing a training schedule, including assisting and monitoring staff to access the online training.</p>	<p>i). There is no evidence of a documented annual education and training schedule for 2023 or 2024.</p> <p>ii). There was minimal evidence of training being provided since August 2022 and all of 2023. There has been no documented training for mandatory subjects including (but not limited to): advocacy; Code of Rights; privacy; informed consent; complaints; abuse and neglect; falls prevention; infection control; challenging behaviour; pressure injury prevention; cultural training; medication; and continence.</p> <p>iii). The infection control coordinator (CNM) has not completed external training on infection control in the previous 12 months.</p>	<p>i). –ii). Ensure an education planner is documented and implemented and includes all mandatory training.</p> <p>iii). Ensure the infection control coordinator completes external education.</p> <p>60 days</p>
<p>Criterion 3.2.3</p> <p>Fundamental to the development of a care or support plan shall be that:</p> <p>(a) Informed choice is an underpinning principle;</p> <p>(b) A suitably qualified, skilled, and experienced health care or support worker undertakes the</p>	PA Moderate	<p>The service has comprehensive policies related to assessment, support planning and care evaluation. Registered nurses (CNM and owner/RN) are responsible for completing assessments (including interRAI), developing resident centred care interventions, and evaluating the care delivery six-monthly or earlier</p>	<p>i). One resident with recent changes in mobility, and an increase in pain did not have interventions and associated risks documented.</p> <p>ii). Two residents assessed with behavioural requirements risk did not have interventions documented to manage the risk.</p> <p>iii). One resident with seizures had</p>	<p>(i). – (vi). Ensure care plans have detailed interventions documented to provide guidance to staff on care management and are updated to reflect changes to resident needs and management</p>

<p>development of the care or support plan; (c) Comprehensive assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People's care or support plan identifies wider service integration as required.</p>		<p>as residents needs change. The service seeks multidisciplinary input as appropriate to the needs of the resident. The care plans are individualised and reflect resident preferences; however, not all assessments and care plan interventions were documented in sufficient detail to guide the resident needs.</p>	<p>an action plan in a paper-based file; however, there was no reference or management strategies documented in the care plan.</p> <p>iv). One resident with a history of cardiac risks did not have associated risks or interventions documented in the care plan.</p> <p>v). One resident with recommendations by speech language therapy in relation to dietary needs, supervision and positioning did not have these documented in the care plan.</p> <p>vi). One resident with specific instructions from a wound nurse specialist did not have these documented in either the short or long-term care plan.</p>	<p>plan.</p> <p>60 days</p>
<p>Criterion 3.2.4 In implementing care or support plans, service providers shall demonstrate: (a) Active involvement with the person receiving services and whānau;</p>	<p>PA Moderate</p>	<p>There is an electronic wound management system implemented which documents wounds and a management plan. A review of current wounds identified detailed management plans and dressings occurred as scheduled. The wound</p>	<p>i). Wound assessments and a management plan were not documented for one current resident with a complex wound.</p> <p>ii) A wound register has not been maintained, with evidence of wounds no longer being treated on the</p>	<p>i). Ensure all wounds are documented on the wound register.</p> <p>ii). Ensure the wound register reflects current wounds.</p>

<p>(b) That the provision of service is consistent with, and contributes to, meeting the person’s assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective;</p> <p>(c) That the person receives services that remove stigma and promote acceptance and inclusion;</p> <p>(d) That needs and risk assessments are an ongoing process and that any changes are documented.</p>		<p>register documents all wounds; however, wounds which have healed or where the resident is no longer at Pacific Haven have not been closed. A current complex wound was being managed with input from the GP and a clinical wound nurse specialist, with information documented in progress notes and email correspondence (sighted); however, the wound and treatment plan was not documented in the wound register.</p>	<p>register for several months.</p>	<p>90 days</p>
<p>Criterion 3.2.5</p> <p>Planned review of a person’s care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;</p> <p>(b) Include the use of a range of outcome measurements;</p> <p>(c) Record the degree of achievement against the person’s agreed goals and aspiration as well as whānau goals and aspirations;</p> <p>(d) Identify changes to the person’s care or support plan, which are agreed collaboratively through the ongoing re-</p>	<p>PA Moderate</p>	<p>There are policies and procedures that provide guidance on assessment and support planning timeframes and processes. Six-monthly reviews where required were not always completed within required timeframes as per policy.</p>	<p>i). Three of five long-term care plan evaluations had not been completed six-monthly.</p> <p>ii). Three short-term care plan evaluations did not evidence evaluation since commencement between two and five months previously.</p> <p>iii). The care plan evaluations of five of five files reviewed did not document progress towards the goals.</p>	<p>i)-ii). Ensure care plans evaluations occur as per policy and legislative requirement.</p> <p>iii). Ensure care plan evaluations reflect progress towards the goals.</p> <p>60 days</p>

assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.				
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	There are medication policies documented that align with current guidelines and legislation. Medications are safely stored in locked trolleys and cupboards in the nurses' station. The policy states eyedrops are dated on opening and discarded as per manufacturer's instructions; however, on the day of audit not all eyedrops were dated.	i). Three eye drops not labelled with an opening date, were in current use. ii). Clonazepam has been dispensed into a container by staff but does not evidence an opening date. iii). Effectiveness of 'as required' medication is not recorded in the medication system or in progress notes.	i-ii.) Ensure eye drops are stored and discarded as per manufacturer's instructions. iii). Ensure effectiveness of 'as required' medication is documented. 60 days
Criterion 3.4.4 A process shall be implemented to identify, record, and communicate people's medicinerelated allergies or sensitivities and respond appropriately to adverse events.	PA Moderate	The respite resident paper-based medication chart included medical officer authorisation; however, the medication chart did not have photo identification and allergies were not documented.	One paper-based medication chart did not have photo identification and allergies documented.	Ensure paper-based medication charts include photo identification, and allergies are documented. 60 days
Criterion 5.2.2 Service providers shall have a clearly defined and documented	PA Low	The infection control programme has been developed by an external contractor with links to infection	The infection control programme has not been evidenced as reviewed and reported on annually.	Ensure the infection control programme is reviewed and reported

<p>IP programme that shall be: (a) Developed by those with IP expertise; (b) Approved by the governance body; (c) Linked to the quality improvement programme; and (d) Reviewed and reported on annually.</p>		<p>control expertise and approved by the management team. The programme links to the electronic quality improvement programme; however, the service has not reviewed the programme annually.</p>		<p>on annually. 90 days</p>
<p>Criterion 5.4.3 Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.</p>	<p>PA Low</p>	<p>All infections are entered into the electronic management system which includes the option of running reports and reviewing infections on a monthly and annual basis; however, this was not evidenced for 2022 or 2023.</p>	<p>i). Infection surveillance data is not monitored and analysed for trends, monthly and annually. ii). Pacific Haven Village does not yet incorporate ethnicity data into surveillance methods.</p>	<p>i). Ensure infection surveillance data is monitored and analysed for monthly and annual trends. ii). Ensure ethnicity data is incorporated into surveillance reporting. 90 days</p>
<p>Criterion 5.4.4 Results of surveillance and recommendations to improve performance where necessary shall be identified, documented, and reported back to the governance body and shared with relevant people in a timely manner.</p>	<p>PA Low</p>	<p>The owner managers maintain regular communication with the management team at Pacific Haven. On interview, the owner manager/RN confirms a knowledge of infection surveillance data at Pacific Haven; however, there is no documentation to support this.</p>	<p>There is no documented evidence of formal infection surveillance reporting to the owners.</p>	<p>Ensure there is documented evidence of infection surveillance reporting to the owners. 60 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

No data to display

End of the report.