Agape Care Warkworth Limited - Leigh Road Cottage

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Agape Care Warkworth Limited
Premises audited:	Bethany Hill Dementia Care
Services audited:	Dementia care
Dates of audit:	Start date: 8 October 2109 End date: 8 October 2019

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: 19

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Agape Care Warkworth Limited – Bethany Hill Dementia Care provides care for up to 30 residents requiring secure dementia level care.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board (DHB). The audit process included the review of applicable policies, procedures, residents' and staff files, observations and interviews with family members, a general practitioner, the facility manager/owner and staff. The owner became the facility manager in February 2018.

There were eight areas requiring improvements from the previous certification audit in January 2018. The four areas related to controlled drugs management, having the dietitian review the menu, some aspects related to the environment, and staff education have been addressed. The four prior aspects for improvement related to complaints management, policy/procedure documentation, maintaining appropriate recruitment records/undertaking staff performance appraisals, and the residents' external access area continues to require improvement. In addition, at this audit, there are eleven new areas identified as requiring improvement related to the facility manager's role and education records, ensuring staff meeting minutes are appropriately detailed, undertaking internal audits/surveys, corrective action planning, essential notifications, incident reporting/management, and staff orientation and ongoing training. The staff medicine competency assessment process, registering a food safety plan and appropriately securing a fire extinguisher are also areas requiring improvement. The family members interviewed were satisfied with the services provided.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Open communication between staff and families is promoted and confirmed to be effective. There is access to interpreting services if required. Staff provide families/enduring power of attorney (EPOA) and/or representatives with the information they need to make informed decisions and to give consent.

The complaints management policy aligns with requirements, and family members interviewed were aware of the process. There have been no complaints received from the Office of the Health and Disability Commissioner or other external organisations.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Business and quality and risk management plans include the scope, aim, goals, values and mission statement of the organisation and processes for monitoring hazards and risk. The facility manager is also the owner and is a registered nurse. Two registered nurses experienced in aged related residential care are employed to provide oversight of residents' care needs.

Policies and procedures have been obtained from an external consultant. There are staff meetings occurring.

Staff have access to ongoing education. All employed and contracted registered health professionals have a current annual practising certificate.

There is always a minimum of two staff on duty and a registered nurse and facility manager are on call.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurses and the general practitioner assess residents' needs on admission. Care plans are individualised based on a comprehensive range of information and identify any new problems that might arise. Records reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated regularly and within the required timeframes.

The activity programme provides residents with a variety of individual and group activities and maintains their links with the community where possible. Activities are provided twenty-four hours a day during the times residents are awake and/or are restless.

Medicines are stored appropriately. Hard copy medication records are maintained. The residents' individual medications are reviewed three monthly by the general practitioner.

The food service meets the nutritional needs of the residents with special needs being catered for. Food safety is managed. Family members interviewed verified satisfaction with the meals provided to their relatives.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

There was a current building warrant of fitness. Ongoing refurbishment and renovations have occurred inside and outside the building. There have been no changes required to the fire evacuation plan since the last audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Restraints and enablers were not in use. Policies are available to guide staff.

Infection prevention and control

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

Aged care specific infection surveillance is undertaken, and results are reported to staff. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	8	0	1	6	2	0
Criteria	0	26	0	3	7	5	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Moderate	The service has a documented complaints policy that complies with the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood their responsibilities in reporting any concerns or complaints to the registered nurse on duty or the facility manager/owner. Not all complaints are detailed in the complaints register. Documentation related to complaints investigation and follow-up is not consistently occurring. The shortfall from the previous audit is now raised in criterion 1.1.13.3. The facility manager/owner reported there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), or Accident Compensation Corporation (ACC) since the last audit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an	FA	Family members interviewed stated they were kept well informed about any changes to their relative's health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. The RN interviewed understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code. Interpreter services are available through the DHB but rarely required due to the nature of this service.

environment conducive to effective communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Moderate	The facility manager/owner has a business and risk management plan that details the services philosophy, mission statement, purpose, aim and values. The scope of services provided is noted as being dementia level of care only. There are documented goals detailed. The facility manager/owner advised that progress towards achieving goals occurs via discussion with staff and family members and completing a range of activities to maintain and enhance the environment. On the day of the audit there were 19 residents receiving services including one resident receiving respite services. The facility manager/owner advised all of the residents have been assessed as requiring dementia level aged related residential care (ARRC). The service has a contract with Waitemata District Health Board (WDHB) for the provision of Age Related Residential Care Services. In addition, there is a Long Term Care Chronic Health Conditions Contract for respite dementia and dementia care. The facility manager/owner advised there are no residents currently receiving services under this contract. The facility manager/owner also owns another aged related residential care service. A shortfall is identified in relation to ensuring the facility manager/owner has sufficient time to complete the responsibilities of the role and having available the facility manager/owner training records.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA High	The quality and risk programme includes complaints/concerns and compliment feedback, staff meetings, discussion on adverse events, infection surveillance and restraint minimisation. An RN is responsible for facilitating the infection surveillance programme and reporting on residents' infections at the staff meetings and monitoring themes and trends over time (refer to 1.3.5). The staff meeting minutes sighted did not include information on the surveillance results. A summary is made monthly of the incidents that have been reported. This information is discussed at staff meetings. Not all events are being linked to the incident management system (refer to 1.2.4.3). While staff meetings are occurring approximately two monthly, the minutes of meetings do not explicitly include all the discussions that are reported by staff to occur including surveillance results and restraint minimisation. This is an area requiring improvement. Updated policies and procedures have been obtained from an external consultant. However, only the updated clinical policies have been printed for staff. The other staff do not have access to the current version of the other policy/procedure documents. This is an area continuing to require improvement. A health and safety policy is available that includes a flow chart to guide staff. An HCA interviewed on this topic advised that the RN or facility manager/owner would be informed of any new hazards. Actual and potential risks are identified associated with human resources management, legislative compliance, contractual risks and clinical risk. This includes when updating resident interRAI assessments. The hazard register identifies hazards and showed the

		actions put in place to isolate or eliminate risks. The facility manager/owner is responsible for oversight of the health and safety programme and hazard elimination/management. Shortfalls are also identified in relation to undertaking internal audits and satisfaction surveys, and corrective action planning.
Standard 1.2.4: Adverse Event Reporting 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.	PA Moderate	There is a policy and procedure that provides guidance for the reporting and management of accidents and incidents. Records related to essential notifications made since the last audit were not available for review. Records were not available to demonstrate that medicine accidents/incidents are being reported via the incident management programme or included in the monthly incident/accident analysis data sighted. While there are documented investigations and follow up for some reported accidents/incidents, this was not consistent.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	Copies of the annual practising certificates for all employed and contracted registered health professionals were sighted. This included for the facility manager/owner, the two registered nurses, the general practitioner, pharmacists, and podiatrist. The shortfall identified at the last audit in relation to demonstrating the recruitment processes and undertaking annual staff performance appraisals continues to be an area requiring improvement. The area raised at the last audit related to training required by the activity's coordinator and infection prevention and control nurse have been addressed. New shortfalls are identified in relation to retaining records to demonstrate staff have completed orientation, and new aspects related to staff ongoing education/training. Some staff are overdue completion of medicine competencies (refer to 1.2.4.3 and 1.3.12.3).
Standard 1.2.8:	FA	There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. The

Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		policy includes the staffing requirement in-line with the contract with the DHB. The rosters evidenced staffing levels exceed the minimum requirements, with adjustments made based on resident numbers, dependency levels of residents and the physical environment. The facility manager/owner is a RN and is at the facility at least two or three days per week. There is another RN on duty weekdays and on call when not on site. The RN interviewed advised she normally arrives on site around 10 am on her rostered days and stays until after the residents' evening meal. This facilitates observation and assistance with any 'sundowning behaviours' and also enables the RN to monitor resident's dietary and fluid intake at two meals in the day. The RN shifts are shared by two experienced aged care nurses who are both reported to have current interRAI competency. There are currently three HCAs on the morning shifts. One has a supervisory role and works four days a week and is covered the other weekdays by an HCA working 7 am to 12 pm as 'float'. On weekends either the supervisor works or the third HCA works a full morning shift. The supervisor works morning shifts with both of the RNs and assists with communication between the two RNs and care staff. There were two HCAs working the full afternoon shifts and night shifts. The HCAs were allocated to care for residents in a designated area of the facility. There was another HCA on duty from 3 to 8 pm. The roster for 30 September 2019 to 13 October 2019 included details of staff who covered for staff unplanned absences. There were dedicated hours for cleaners (9.30am to 12.30 pm weekdays), activities (9 am to 3.30 pm weekdays), kitchen staff (8 am to 1 pm and 3.30pm to 6 pm every day) and for laundry services. The facility manager/owner advised there are currently no staff vacancies, and the morning 'float' shift will be removed commencing with the next roster due to changes in resident numbers. The RN who is working on the day was rostered on call after hours with back up from the facility manager/owner. The FM was on call for non-clinical matters. Care staff interviewed reported adequate staff were available to complete the work allocated to them. Families interviewed reported the number of staff on duty was suitable for the provision of care. Observations during this audit confirmed adequate staff cover was provided. Improvements have been identified in relation to aspects of staff training (refer to 1.2.7.5 and 1.3.12.3).
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	PA High	The medication management policy reviewed identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. Hard copy medication records are maintained. One of two staff observed administering medicines on the day of the audit demonstrated poor knowledge of the role and the responsibilities related to each stage of medicine management. Staff training records reviewed evidenced that not all applicable staff had completed the medicine competency training programme, or, on some occasions when the training had been undertaken the records were incomplete and not dated and/or signed. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs are responsible for checking the medications against the prescription when delivered from the pharmacy. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly and as

guidelines.		requested. Controlled drugs are stored securely in accordance with requirements and balances are checked by two staff weekly for accuracy and when administering. This was an area of improvement identified in the previous audit which has been addressed. The small fridge in the medication cupboard is checked daily and the temperature is recorded and was within the normal range. Good prescribing practices were noted and included the prescriber's signature, registration number and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were met. The required three monthly GP review was consistently recorded on the medicine chart. The GP interviewed stated that he works collaboratively with the pharmacist and the two RNs at this facility. There were no residents who were self-administer medications at the time of audit. This would not occur due to the nature of this service. The staff minutes of meetings held evidence medicine errors were discussed. Incident forms were not present in the incident documents provided for review during audit (refer to 1.2.4.3).
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low	The food service is provided by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian. The dietitian was contracted 18 September 2018 to oversee and provided specialised dietetic and food service advice. This was an area of improvement identified in the previous audit which has been addressed. Recommendations made at the time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal was reviewed. The food control plan was not able to be verified at this onsite audit. The cook explained that the verification audit with the local council is yet to be scheduled to meet legislative and guideline requirements. Food temperature monitoring is occurring including for all high risk items and temperatures are accurately recorded. Fridge and freezer monitoring is included and the cook ensures this is completed in a timely manner. The cook has completed appropriate food handling training. Another relief cook is available to cover the main cook for leave. No kitchen hands are employed. Kitchen cleaning schedules were sighted for weekly and daily additional cleaning to be completed. The night duty care staff also have some responsibilities for cleaning the kitchen and two dining rooms and this system works effectively. All kitchen areas were clean and tidy. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to the cook and accommodated in the daily meal plan. Food and fluids are available to meet the residents' nutritional needs at all times of the day and night. Family members interviewed verified satisfaction with the meals provided to their

		relatives. Special equipment to meet resident's needs is available if required.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and care plan. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed verified that medical input is sought in a timely manner and that medical orders are followed. Care staff interviewed confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme is provided by two staff, both activities coordinators. One covers three days a week and the other two days a week. Staff provided activities in the weekend and resources are available. A social assessment and history is undertaken on admission to ascertain residents' interests, abilities and social requirements. The activities assessments are regularly reviewed to ensure the activities planned are meaningful to the residents. The resident's activity needs are evaluated six monthly and as part of the formal six monthly care plan review. The activities are planned for each wing and colour coded on the activities plan sighted. Van outings occur daily and are enjoyed by the residents as all were mobile in this dementia care service. Activities for residents in this secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when most residents are physically active and/or restless. Activities cover the twenty four hour period and all residents have a personalised individual activities plan in their records reviewed. This included one-on-one activities, gentle music, arts and crafts, seated exercises, and walks along the beach. The activities coordinator interviewed has completed training over the last two years related to planning the activities programme for residents with dementia. This training was provided by an occupational therapist.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the activities and therapies notes (progress notes) used by the provider. If any change is noted it is reported to the RN. Formal care plan evaluations occur six monthly in conjunction with the six monthly interRAI re-assessment, or as the resident's needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for skin tears, wounds, urinary tract infections and an eye infection. When necessary and for unresolved problems long term care plans are added to and updated as needed. Families interviewed provided examples of involvement in evaluation of progress and any relating changes. The GP interviewed stated he was

		always willing and able to speak with family/whanau as arranged by the RN.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate	A current building warrant of fitness was displayed that expires on the 22 February 2020. Remedial work has been undertaken for the shower floor in the Takahe wing that was reported to slope towards the door instead of the waste outlet. This has been addressed and the waterflow observed appropriately draining when checked during audit. A cleaning and painting programme has been undertaken of the external areas of the facility including painting the roof and previous external wall areas that required this. The facility is maintained. Some refurbishment and renovation has occurred within the internal areas and residents' bedrooms as they become vacant. Wallpaper feature walls have been effectively used inside the facility to provide colour and create points of interest for residents. There was no moss visible growing on the external walls. The garden areas were well maintained including pathways. These shortfalls from the last audit have been addressed. While some work has been undertaken to reduce resident's potential access to the area above a retaining wall, this area remains potentially accessible by residents and requires further improvement.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate	The facility manager/owner advised there have been no changes required to the fire evacuation scheme since the last audit. The emergency management plan is overdue for review (refer to 1.2.3.3). Orientation and ongoing fire evacuation education records are not consistently maintained (refer to 1.2.7.5 and 1.2.7.4). Fire equipment sighted had been checked within the last 12 months. A fire extinguisher is being moved around the facility. This requires improvement.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. The RN infection prevention and control coordinator was not available for the audit; however, the RN rostered on the day explained the documentation in the infection control folder reviewed. Any new infections are discussed at the time of handover to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends or positive factors or if any required action is required. The RN stated that results of surveillance are shared with staff at the staff meetings and at staff handovers. The results were not included in the staff meeting minutes sighted (refer to 1.2.3.5). The infection rates

have been specified in the infection control programme.		sighted were low. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There were no residents with restraints or enablers in use due to the nature of the service. Policies and procedures are available to guide staff practice. An HCA interviewed could detail what restraints and enablers are and the distinction between the two.

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Moderate	There is a form that family members can document complaints or express compliments. The complaints register sighted included details of three complaints received since the last audit. The two complaints received in January 2018 have been investigated and responded to within required timeframes that align with the Code. The written complaint received dated 8 October 2018 has not been recorded in the complaints register. The facility manager/owner advised attempts were made to contact the complainant via email and were unsuccessful. There are no records to demonstrate any attempts/follow up in relation to this complaint. The staff meeting minutes in December 2018 includes reference to complaints received about the driveway, and that the issue had been addressed. The complaints register does not include any information on these complaints. Three family members interviewed were aware of the complaints process and have not made any complaints.	The complaints register does not include details of all complaints received. Records are not available to consistently demonstrate that all complaints have been acknowledged, investigated and responded to in a timely manner.	Ensure the complaints register includes details of all complaints and that records are retained to demonstrate that all complaints have been investigated and responded to within timeframes that align with the Code. 60 days

Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.	PA Moderate	The facility manager is the owner and manager of two aged related residential care (ARRC) services. One of the (ARRC) facilities has been owned for longer that Bethany Hill Dementia Care, and is located in Orewa, Auckland and provides rest home and dementia level services. The other facility is Bethany Hills Dementia Care. This service was renamed as at 1 April 2018. The facility manager/owner advised the name change was to be more reflective of the values and care focus included in the service's philosophy. Previously the administrator was also the facility manager, who left employment at this facility in February 2018. Since February 2018, the owner became the facility manager. The owner advised this change in facility manager was reported to HealthCERT. The facility manager/owner is a registered nurse with a current annual practising certificate. The facility manager/owner reports being on site at Bethany Hill Dementia Care at least two and usually three days a week; normally arriving around 11 am and leaving late afternoon. The FM advised she is responsible for employment, human resources management, implementing the quality and risk programme, overseeing staff training and all accounts management. The FM advised there are time pressures and activities are prioritised that are related to resident care. Refer to the areas for improvement raised in this audit. The facility manager/owner advised she attends regular meetings (alternate months) with other aged related residential care (ARRC) facilities. These meetings are approximately four hours in duration, and the FM advised she has attended three meetings in 2019 to date. However, no records were available to demonstrate this, or the facility manager/owner's attendance at any other education in the last 12 months. Some training records are reported to be kept at the facility manager/owner's other facility. The facility manager/owner was unable to access most historic email communications during audit. The FM advised that an unforeseen event two weeks prior to this audit has resulted in all email communications sent and received prior to this time as no longer accessible. The facility manager/owner is working with the information technology provider to address this issue, but to date this has been unsuccessful. There are two registered nurses employed who have oversight of the day to day clinical care provided to residents. There is a RN on site weekdays	The facility manager is the owner and manager of two aged related residential care services. While the facility manager/owner is on site at Bethany Hill Dementia Care at least two and normally three days a week, this is insufficient time to complete all activities required by the facility manager. Records are not available to demonstrate that the facility manager/owner has attended more than eight hours of education per annum as required to meet the provider's contract with Waitemata District Health Board.	Ensure the facility manager roles and responsibilities can be effectively undertaken. Maintain records to demonstrate the facility manager/owner has attended at least eight hours of education per annum as required to meet the providers contract with WDHB. 60 days

		and on call when not on site. The RN interviewed advised the facility manager/owner keeps in touch with the two registered nurses about day to day issues via a private messaging programme or is contactable by phone. One RN assists with drafting the roster and one RN is responsible for infection prevention and control activities and restraint minimisation. The two RN's are assisting with incident management and follow up and some staff training.		
Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Moderate	Since the last audit, updated policies and procedures have been obtained from an external consultant electronically. These documents are available electronically to the registered nurses only. All other staff are reported to not have access to electronic documents. The updated clinical policies have been printed and made available for all care staff, including the medicines management policy. The cleaning manual available for staff is dated as reviewed in December 2016. The emergency procedure manual is dated as reviewed in May 2016, and the food services manual sighted is dated as last reviewed in November 2013. The facility manager/owner advised polices are required to be reviewed every two years or sooner if required. The facility manager/owner is responsible for document control processes.	Updated policies and procedures have been obtained from an external consultant. However, only the updated clinical policies have been printed and made available for staff. The copies of the printed policies/procedures available for staff reference, including the cleaning manual, laundry manual, food services manual and emergency procedures are overdue for review.	Ensure current policies and procedures are available for staff, and that document control processes are consistently implemented to remove out of date policy / procedure documents from use. 90 days
Criterion 1.2.3.5 Key components of service delivery	PA Low	The staff meeting minute template includes an area to discuss event reporting/incidents, infection prevention and control, health and safety and restraint minimisation along with other issues/topics. The meeting	The meeting minutes for one out of five staff	Ensure key components of service delivery

shall be explicitly linked to the quality management system.		minutes for five staff meetings were sighted for meetings held between 15 August 2018 to 19 August 2019. One of the meeting minutes contained information on one reported event/incident only. An RN and a health care assistant (HCA) interviewed advised more information is usually discussed at these meetings and includes the results of the infection surveillance programme, infection rates and trends, restraint minimisation, and health and safety, and some aspects related to residents' care needs or the facility and processes, although these topics are not always detailed in the meeting minutes, to help inform staff who were not present at the meeting. None of the meeting minutes or attachments sighted included information on the results of the infection surveillance programme (refer to 1.3.5). Restraint minimisation is included in discussions in one meeting only. There is a signing sheet for staff to sign attached to the minutes. The internal audit framework included a range of audits and an annual family satisfaction survey, and staff satisfaction survey to enable monitoring of key aspects of service delivery/resident care, staff education/training and the facility. Audits and surveys have not been completed since May 2018 (refer to 1.2.3.7). The last family satisfaction survey was completed in January 2018 prior to the last audit. The family members interviewed were satisfied with the services provided.	meetings sighted explicitly includes discussions on restraint minimisation. The infection surveillance results (numbers and trends over time) reported to be discussed at staff meetings are not included in any of the five meeting minutes sighted.	are explicitly linked to the quality and risk programme including infection prevention and control and restraint minimisation. 90 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Moderate	There is a comprehensive internal audit programme which details topics for inclusion in the internal audit and satisfaction survey schedule and the frequency these are to occur. There are template audit tools available for each of these audits/surveys, and topics includes aspects of care, documentation, compliance with policy/procedures, building compliance and assessing family satisfaction with services provided. The internal audit framework includes an area to monitor aspects of staff education/training including completion of fire, first aid training and challenging behaviour management. The facility manager/owner advised the last completed internal audits/surveys were conducted in May 2018. This was reflected in the completed internal audit documentation sighted. Sampled audits completed for the period January 2018 to May 2018 included staff education, safety, privacy of information, complaints and review of staff files. Where audits have been completed, action plans have not been consistently developed when areas for improvement are	Internal audits and surveys have not been undertaken since May 2018.	Undertake internal audits and satisfaction surveys as scheduled in the internal audit schedule. 90 days

		noted as required, or when developed, there is no evidence of monitoring or follow-up (refer to CAR 1.2.3.8).		
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA High	Where internal audits identified areas requiring improvement, action plans have not been consistently developed or if developed do not specify time frames for when the actions are to be undertaken. There was no evidence of any monitoring to ensure the required actions have been undertaken and were effective. The findings of the staff file audit (May 2018) were also sighted during this audit (no records of police vetting, performance appraisal or references in some audited staff files including staff employed since the last audit). Refer to criterion 1.2.7.2 It was identified that staff required training in de-escalation and managing challenging behaviour when a staff member responded to a resident's challenging behaviour in an inappropriate manner (April 2019). Records were not available to verify that this training has since been completed. It was unclear what if any follow-up was has occurred with the staff member. In response to another reported incident involving two residents (August 2019), one residents' updated care plan evaluations detailed that a sensor mat is to be used to monitor a resident's mobility. A subsequent incident report later the same month (related to a different resident) noted that staff require training on sensor mat use. There was no evidence at audit as to whether this training has been scheduled or has occurred (refer to 1.2.7.5). The investigation and actions taken in response to two other sampled accidents/incidents events were not documented on incident reports sampled (refer to 1.2.4.3). With the exception of the discussions at staff meetings, indicating that staff medicine competency assessments need to be updated (in progress as at audit – refer to 1.2.4.3 and 1.3.12.3), action plans in relation to the medicine events noted in staff meetings was not sighted.	Corrective action plans have not been consistently documented when areas for improvement are identified / required. This included in response to adverse events / incidents and internal audits (when completed). Required actions are not always undertaken in a timely manner or monitored for effectiveness.	Ensure corrective action plans are developed when areas for improvement are identified, including detail of the improvements required, by whom and timeframes. Implement a process to monitor that required actions are undertaken and are evaluated for effectiveness. 30 days
Criterion 1.2.4.2 The service provider understands their	PA Low	The facility manager advised essential notifications have been made in relation to the change of facility manager (February 2018), a resident absconding (May 2019) and an outbreak of infection (notified in May 2019 by the RN responsible for infection prevention and control). However,	The facility manager/owner advised three essential	Ensure essential notifications are made when required, and

statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.		records were not available in relation to these events. The facility manager advised that due to an unforeseen event two weeks prior to audit, all email communications sent and received prior to this date are inaccessible. The facility manager/owner advised the resident event in late 2017, that was reported to the Coroner remains open.	notifications have been made since the last audit. Records were not available in relation these.	records are retained of these communications. 180 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA High	Staff are reporting a range of adverse events and incidents. Sampled events included episodes of challenging behaviour and residents' falls. At least eight reported events were sampled, from the incident data provided. Some events included details of investigation and actions taken; however, this was not consistent. The results of the investigation and actions taken were not documented on the incident report for at least two of these events, for events that had occurred at least 30 days prior (refer to 1.2.3.8). Four out of five staff meeting minutes sighted for the period 15 August 2018 to 19 August 2019 included discussion on medicine related incidents. This included crushing medicines and mixing with food, not signing controlled drugs into the controlled drug (CD) register, and 'missing' medicines - reminding staff to complete 'the 5 rights'. Incident reports for medication events were not present in the provided incident data or referenced in the data monthly incident/accident analysis summary forms sighted for the period April 2019 to August 2019 (refer to 1.2.3.8). One of the two caregivers observed administering medicines during audit had not completed medicine competency processes and safety concerns were identified during the observed medicine round (refer to 1.3.12.3).	Medicine errors / incidents discussed during the last three staff meetings as detailed in meeting minutes sighted have not been included in the incident data sighted for the period April 2019 to August 2019. While some adverse events / incidents sampled contained details of investigation and follow-up, this was not consistent.	Ensure all adverse, unplanned and untoward events including service shortfalls are documented as incidents. Investigate and follow-up all reported events/incidents in a timely manner. 30 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of	PA High	The facility manager/owner advised the recruitment process includes staff completing an application, conducting interviews, obtaining reference checks of the successful applicant and conducting police vetting, as well as new staff signing individual employment agreements that includes a confidentiality statement. Applications and employment agreements, that includes a confidentiality agreement were present in all sampled files.	Records are not available to demonstrate the recruitment process consistently	Human resources appointment processes are consistently completed for all staff including

consumers.		However, records evidencing reference checks, interviews and police vetting are not present in some staff files. These records were missing from the files of staff employed in June 2018, January 2019, and February 2019. The facility manager/owner advised police vetting is conducted and electronic records are maintained related to this process. However, the facility manager/owner was unable to access these records during audit, due to unforeseen events that have made historic email communications no longer accessible/available. The facility manager/owner's attempts to log on to the police vetting website were not successful due to logon or password errors. There is no record of the results of police vetting in these sampled files. Two staff have performance appraisal templates in their personnel files, with information recorded; however, these documents are not dated and/or signed. One HCA appraisal was dated as last completed in May 2018, and an appraisal in another staff file is dated August 2016. There were no appraisal records present in five other staff files sampled for employees who have been employed for more than 12 months. The facility manager/owner confirmed being aware these are overdue. The sample size was expanded during audit.	includes interviews, conducting reference checks and police vetting including for three staff employed since the last audit. Job descriptions are also missing from at least three staff files sampled. Annual performance appraisals present in two staff files were not dated and/or signed. Appraisals were overdue in seven of seven staff files reviewed for staff employed more than 12 months.	police checking, reference checks, position descriptions and annual performance appraisals and records are retained. 30 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Moderate	A caregiver interviewed, employed less than 12 months confirmed being provided with an orientation relevant to the staff member's role and responsibilities. This included being 'buddied' with another caregiver for several shifts and working through an orientation checklist. The orientation template checklist sighted included an orientation to the facility, individual residents, emergency procedures, incident reporting, and key policies. Records demonstrating staff have completed the orientation requirements were missing from at least four staff files sampled (for staff employed in May 2017, June 2018, January 2019 and February 2019).	Staff reported they were provided with an orientation relevant to their role. However, records were not available to demonstrate this had been completed in four out of ten staff files sampled.	Ensure staff are provided with an orientation relevant to their role and records are consistently retained to demonstrate this. 90 days

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	The two registered nurses have a current first aid certificate. The HCAs that completed first aid training undertook this on 6 September 2017, with certificates dated as valid for two years. The facility manager/owner stated that she thought there was another three months 'grace period', after this date where staff were still considered current. Except for the shifts with an RN on duty, the service is unable to demonstrate that there is a staff member on duty with a current first aid certificate. There is a staff in-service education/training programme that includes more than eight hours of education in the year. This includes in-service education sessions and staff being required to complete online education modules via an external organisation that provides training opportunities for ARRC providers. In-service sessions are provided by the DHB gerontology nurse specialists. Records of attendance at in-service sessions are maintained. Care staff are also required to complete online education modules. The facility manager/owner reviews completion records as time permits and notes this on a register which was sighted. In the 2019 education records sighted, five staff are noted to have completed the complaints e-learning module (February 2019), two staff have completed the e-learning module on observations/report/documentation (February 2019); four staff have completed the hydration e-learning module (April 2019); and two staff have completed the pressure injuries and pressure care e-learning module (May 2019). Records were not available to identify the names of staff that have completed the e-learning training on restraint minimisation, dementia care and continence / incontinence management e-learning modules during the period June to September 2019. Records to demonstrate that staff have completed training on managing challenging behaviour were not available (refer to 1.2.3.8). The facility manager/owner advised working to try and improve e-learning module completion rates, and to develop a system to monitor completion data more frequently. The education records available for review did not include information of when the last fire evacuation drill was completed. The facility manager/owner was confident this had occurred earlier in 2019; however was unable to locate records. The HCA interviewed confirmed that in service education has been provided relevant to their role and responsibility and this included completion of e-learning	A staff member with a current first aid certificate is not always rostered on duty. Two health care assistants employed more than 18 months have not yet completed an industry approved qualification in dementia care. Records are not available to demonstrate a fire drill has been completed in the last 12 months. The process of monitoring and follow-up that applicable staff are completing required education is not consistently occurring in a timely manner.	There is at least one staff member on duty with a current first aid certificate. Applicable care staff complete an industry approved qualification in dementia care within eighteen months of employment. Provide regular fire evacuation training for staff and retain records. Monitor that staff are completing ongoing education in a timely manner. 90 days

		modules. Of the 14 employed HCAs; six HCAs have completed an industry approved qualification in dementia care with records available to support this. Two HCAs employed for more than 18 months have started but not completed an industry approved qualification in dementia care as confirmed by the facility manager/owner. The other HCAs have been employed less than 12 months, with two HCAs employed less than six months. The facility manager/owner confirmed being aware of the ARRC contract requirements in relation to staff training. The activities coordinator has attended education with an occupational therapist to assist planning and facilitating an activity programme relevant to a dementia care service. The registered nurse responsible for infection prevention and control has completed an online training programme on infection prevention and control since the last audit. This aspect now meets the standards.		
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA High	The lunchtime medication round was observed. Two care staff were responsible for this role. Both were working at the time in two different dining rooms. One staff member was observed who did not administer the medicines in a safe manner. The staff member signed for all medications prior to administration. Liquid medicines were measured and left on the top of the trolley covered with a tea towel. The medication cupboard was left wide open prior to commencing the round with no staff member in attendance. This was urgently addressed at the time. On several occasions the staff member left the dining room and medicine trolley unattended. The RN was informed at the time. The other HCA was observed to have a safe medicine management and documentation process. Health care assistants and the two registered nurses administer medications. Records were not available to demonstrate that four HCAs have completed medicine competencies. This included one of the staff member's administering the observed medication round. Three staff were currently in the process of completing the medicine competency and this included a HCA who had completed some of the competencies earlier in 2019. Four medicine competency records sighted had aspects that had	One of two staff members observed administering medicines did not administer medicines in a safe manner. Records were not available to demonstrate this staff member had completed Bethany Hill Dementia Care's medicine competency assessment. Records were not available to demonstrate that three other HCA	Ensure medicines are administered in a safe manner and by staff who have completed the organisation's medicine competency assessment programme. Retain appropriately detailed/completed records of these assessments. 7 days

		not been completed or were not signed or dated by the assessor.	staff who administer medicines have completed the medicine competency assessment training programme. The medicine competency assessment records for four other staff were incomplete and/or have not been dated and/or signed by the staff member undertaking the assessments.	
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	Policies, procedures and guidelines were reviewed which covered all aspects of food safety, procurement, ordering, delivery and disposal of food. There was no evidence that the service has been audited to verify compliance with the Ministry of Primary Industries Food Control Plan. A date has not been arranged or confirmed by management and the local council.	The service does not have a food control plan or date as yet for the verification audit to occur.	Develop a food control plan and have a verification audit of the food services to meet legislative requirements. 90 days
Criterion 1.4.2.6	PA High	The uneven concrete path outside 'HiHi' wing has been addressed. There	The retaining wall	Make the area

Consumers are provided with safe and accessible external areas that meet their needs.		are several walking tracks present for residents to use. A gate has been installed to minimise resident access to the area above the retaining wall located near the raised garden and built by the previous owners. At the last audit, an area for improvement was raised that residents could potentially walk along the top of this wall and fall onto the concrete below. While some remedial work has been completed, the area remains potentially accessible to residents. One resident was sighted climbing over the gate to walk up along the path near this area. A portable chair was sighted laying in the garden area that could also be used by residents to aid climbing over some of the internal walls and gates. There is a separate higher external fence around the property and double gate entrance. Residents were observed frequently independently mobilising out of the main entrance into the resident walkway areas. On other occasions residents were accompanied by staff. Several residents were observed exiting the building from the doorway located by the top dining room, which staff noted is normally a staff exit area and the door kept secure. Several residents were observed frequently checking whether this door would open and gained access after staff had exited the facility via this door in order to undertake required outside tasks. This is not the preferred external area for residents to enter/exit as the pathway from this area is slightly sloped (widthways) and parts of this area is currently also used as a storage area. This area is secure in that residents cannot leave the premises from this exit point.	near the raised garden is approximately 1.5 metres high and can easily be accessed by residents, who could get access to walk along the top of the wall and fall onto the concrete below. A resident was observed walking up on the path near this area, after climbing over one of the internal gates. Residents were observed mobilising in an area that is intended for staff access only – the residents had exited out of the door opposite the 'top dining room'. The residents are unable to leave the grounds from this exit.	leading to the top of the retaining wall safe. Ensure residents mobilise within the external areas authorised for their use. 30 days
Criterion 1.4.7.1 Service providers receive appropriate	PA Moderate	The emergency management plan available for staff access is overdue for review (refer to 1.2.3.3). The facility manager/owner advised there have been no changes to the fire evacuation scheme since the last audit. Records of recent fire evacuation drills could not be located (refer to	A fire extinguisher is being moved about within the	Ensure the fire extinguishers are appropriately secure and

information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.		1.2.7.5). The orientation programme includes fire and security education. Records of orientation are not consistently maintained (refer to 1.2.7.4). Staff interviewed confirmed their awareness of emergency procedures. Fire equipment sighted had been checked within the last 12 months by the fire services contractor. A large fire extinguisher was sighted on the floor or furniture in different corridor areas and rooms throughout the audit. This piece of equipment is being moved about and is not appropriately secure.	facility.	accessible by staff in agreed locations in the event of an emergency. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.