

Archer Care Facility Limited - Archer Village

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 BSI Group New Zealand Ltd, 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: Archer Care Facility Limited

Premises audited: Archer Village

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

Dates of audit: Start date: 13 October 2020 End date: 14 October 2020

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: 48

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Archer Village is governed by a charitable trust and is part of the Archer Retirement Village. The service is certified to provide rest home and hospital level care for up to 54 residents. On the day of audit there were 48 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, staff, the general practitioner and management.

The village manager (non-clinical) has been in her role for two and a half years, she is supported by a clinical manager who has been in the role since December 2019 and has experience in aged care management. They are supported by a general manager, who oversees operations across three sites.

Residents and the general practitioner (GP) interviewed were very complimentary of the services and care they receive.

The five previous partial provisional audit shortfalls have been addressed. All shortfalls were related to introducing hospital level care.

This surveillance audit identified areas for improvement around documentation, interRAI timeframes and aspects of care planning.

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 low risk.
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A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Key components of service delivery is linked to the quality management system. There is an implemented internal audit programme to monitor outcomes. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

There is an electronic reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to the meetings. Relatives are notified of all incidents promptly.

A staff training programme is implemented and based around policies and procedures. Annual resident and relative satisfaction surveys are completed.

Human resources are managed in accordance with good employment practice and meeting legislative requirements. An orientation programme is in place. The service has sufficient staff allocated to enable the delivery of care.

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 low risk.
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The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed on the electronic system demonstrated service integration and were evaluated at least six-monthly. The general practitioner reviews the residents at least three-monthly. Allied health professionals are involved in the care of residents as required.

Medication policies reflect legislative requirements and guidelines. The registered nurses and senior healthcare assistants are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The social events team provides and implements an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness. There is a reactive and planned maintenance programme in place. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Archer Village has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were no residents using restraint or enablers. Staff receive training in restraint minimisation and challenging behaviour management.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The clinical manager is the infection control coordinator. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. Staff complete annual training on infection control.

The Covid-19 lockdown periods were well managed, and logs documented as required. Education sessions were held around hand washing and donning and doffing personal protective equipment. Residents and relatives were kept up to date through newsletters. Staff were updated daily. Adequate supplies of personal protective equipment were sighted. Contact tracing has been maintained, and visitors are required to sign the register which includes a wellness declaration.

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	13	0	4	0	0	0
Criteria	0	42	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The village manager maintains an electronic and paper-based record of all complaints (verbal and written). Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. The complaint folder also contains resident concerns and issues (not complaints) which have been followed up.</p> <p>Six complaints have been logged for 2019 and 2020 (year to date). All complaints documented a comprehensive investigation, follow-up, and replies to the complainant. Complaints all included a section to confirm that the complainant was happy with the outcome. Training and education sessions have been provided to staff where appropriate.</p> <p>Staff interviewed could describe the procedure for directing complaints to the most senior person on duty. Discussions with residents confirmed they were provided with information on complaints and complaints forms. Residents interviewed felt comfortable discussing issues/concerns with the management team.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	PA Low	<p>Comprehensive information is provided at entry to residents and family/whānau. Six residents interviewed (three rest home and three hospital) stated that they were welcomed on entry and were given time and explanation about the services and procedures. The village manager, clinical manager and registered nurses are available to residents and relatives and they promote an open-door policy. Ten electronic incident forms</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>reviewed for September and October 2020, did not always document relatives were notified. Staff interviewed (three healthcare assistants, two registered nurses, and the social events manager) fluently described instances where relatives would be notified. Interpreter services are available when required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Archer retirement village is part of the Archer Group and is governed by a charitable trust board. The Archer Group own three retirement villages, two (including Archer Village) have care centres.</p> <p>The Archer village care centre provides rest home and hospital level care to up to 54 residents. On the day of audit there were 48 residents: 32 rest home including one resident on respite care, and 16 hospital level residents. All long-term residents were under the age-related residential care contract. Archer is governed by a charitable trust board.</p> <p>The general manager oversees the three sites, and reports to the board monthly. The village (site) manager has been in her role for two and a half years. She reports to the general manager on a variety of operational issues and reports to the leadership, quality and risk meeting held monthly. The clinical manager (registered nurse) has been in her role since December 2019 and has previous clinical management and quality experience. They are supported by registered nurses and long-standing healthcare assistants.</p> <p>The service has a current strategic plan, a business plan and a quality and risk management programme. The service mission reflects the Christian values. There are 2020-2021 goals for all departments. Goals for the year include reducing medication errors, the implementation of the electronic system, enhancing the fine dining experience and refurbishments around the facility. Progress toward previous goals has been monitored and documented at the leadership, quality and risk meetings.</p> <p>The village manager has completed the eight hours education in relation to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality and risk management plan describes the company's quality improvement processes. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data collected, is analysed and compared monthly and annually for a range of adverse event data. Where improvements are identified, corrective actions are developed, implemented and regularly evaluated.</p> <p>The combined leadership/quality and risk management meeting is held monthly and is attended by heads of departments across the care centre and village.</p> <p>Minutes of the meeting evidenced discussions from each department and corrective actions outstanding from the previous meeting. Monthly staff and clinical meetings are held, however, discussions around quality data is not documented as occurring during meetings. Staff interviewed reported graphs and charts of data are</p>

		<p>displayed on staff noticeboards and are discussed at handovers as infections and falls occur. Health and safety is incorporated in the leadership/quality meeting. Each department has reviewed the hazard register which was updated in June 2020. The property and maintenance team ensure all maintenance and hazards are dealt with promptly. There is a strong focus on staff wellbeing, with prizes awarded for incident and near miss reporting.</p> <p>The clinical manager completes or delegates clinical internal audits. The village manager completes and delegates non-clinical internal audits. An electronic record of corrective actions is in place. Corrective actions are signed off by the clinical or village manager when completed or remain on the log if ongoing.</p> <p>Annual satisfaction surveys are completed. The results have been collated, analysed and discussed at the leadership/quality and risk meetings. The 2020 surveys have yet to be distributed due to Covid-19.</p> <p>The 2019 resident food satisfaction survey showed overall satisfaction. Eighty-three percent of residents thought there was enough choice on the menu, and 80% reported portion sizes were satisfactory.</p> <p>The resident satisfaction survey evidenced overall satisfaction around (but not limited to) communication, answering of call bells, free of odours, and the activity programme. Areas of lower satisfaction had already been identified by the staff and management. Corrective actions had been implemented by the time the collation had been completed. The service has decided to develop a site-specific survey for 2020 to gain the information they require to improve their service.</p> <p>The relatives' satisfaction survey evidenced 65% were satisfied or very satisfied with the responsiveness of staff in relation to concerns raised, 85% were happy with laundry services, 95% felt there was a high standard of cleanliness, and 70% felt staff were well skilled.</p> <p>Falls management strategies include wireless sensor mats, and the development of specific falls management plans to meet the needs of each resident who is at risk of falling.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual electronic adverse event reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is collated online. Ten electronic resident related accident/incident forms were reviewed. Each event involving a resident reflected follow-up by a registered nurse. Neurological observations are conducted for suspected head injuries, and where possible opportunities to minimise future risks were identified and implemented, however, next of kin notifications were not always documented (link 1.1.9.1).</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. Notifications were made to Public Health following two outbreaks, norovirus in 2018. There has been no requirement to complete section 31 notifications since 2018.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Six staff files reviewed (clinical manger, one registered nurse (RN), one hospitality manager, one social event manager, and two healthcare assistants (HCAs) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of practising certificates was maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Role specific orientations are in place for all roles including registered nurses. The orientation includes manual handling and hoist competencies for all clinical staff. The previous findings from the partial provisional audit has been addressed.</p> <p>A competency programme is in place. Core competencies are completed annually including manual handling, hoists, ceiling hoists, medication, and hand hygiene.</p> <p>There is an annual education and training schedule being implemented with a catch-up plan in place which includes the introduction of an online system.</p> <p>The healthcare assistants undertake aged care qualifications through Careerforce. Currently there is one HCA with New Zealand Qualification Authority (NZQA) level 4, five with level 3, two with level 2 and one with level 1.</p> <p>Education and training for clinical staff is linked to external education provided by the district health board. RN-specific training viewed included: syringe driver, wound care, and first aid. Four RNs and the clinical manager are competent in interRAI. There has been a registered nurse rostered on all shifts prior to the introduction of hospital level residents. the previous finding from the partial provisional audit has been addressed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager (non-clinical) is available Monday to Friday between all sites. The village manager, and clinical manager are full-time Monday to Friday.</p> <p>A resident allocation list is maintained to share the resident load evenly between staff.</p> <p>There are two registered nurses on the day shift Monday to Friday; 1x 8 am to 4.30 pm and 1x 8.30 am to 5 pm. One registered nurse over the weekend from 8 am to 4 pm.</p> <p>The afternoon shift has one registered nurse seven days a week from 4 pm to midnight. There is one</p>

		<p>registered nurse and two HCAs from midnight to 8 am.</p> <p>The morning shift has seven HCAs: 2x 7 am to 3.30 pm, 1x 7.30 am to 4 pm, 1x 8.30 am to 5 pm, 1x 8 am to 4 pm and 2x 8 am to 1 pm.</p> <p>The afternoon shift has five HCAs: 3x 4 pm to midnight, 1x 4.30 pm to 9 pm and 1x 4.30 pm to 9.30 pm.</p> <p>The clinical manager has template rosters too increase staffing as hospital level residents increase in numbers.</p> <p>Residents and relatives interviewed stated there were sufficient numbers of staff on duty to safely deliver residents cares. Staff interviewed felt there was sufficient staff on duty and reported low usage of agency staff.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Medications are stored safely in the fully completed medication room which has keypad entry. The finding from the partial provisional audit has been addressed. Clinical staff who administer medications (registered nurses, and medication competent healthcare assistants) have been assessed for competency on an annual basis and attend annual medication education. Registered nurses have completed syringe driver training. All medication blister packs are checked on delivery against the electronic medication charts. There were four rest home resident's self-administering medication on the day of the audit. Competencies were in place and had been reviewed three-monthly. There are locked drawers available in each resident room.</p> <p>The medication fridge is checked as per policy, and temperatures are maintained within the acceptable temperature range. Medication room temperatures were monitored and were below the recommended 25 degrees Celsius. All eye drops sighted in the two medication trolleys were dated on opening. The medication trolleys were locked when not in use.</p> <p>Twelve electronic medication charts (six rest home and six hospital) were reviewed and met prescribing requirements. Medication charts had photo identification and allergy status notified. The GP had reviewed the medication charts three monthly. 'As required' medications had prescribed indications for use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of</p>	<p>FA</p>	<p>The food services are overseen by a chef. All meals and baking are prepared and cooked on site by qualified chef/cook. All food services staff have completed food safety training. The kitchen has been partially refurbished, with the new ceiling, whiteboard walls and a reconfiguration of the central cooking area complete. The flooring, and installation of the new dishwasher has been delayed due to Covid-19. The previous finding around unpainted shelving has been addressed.</p> <p>There is a current Food Control Plan in place which expires July 2021. The four-week rotating menu has been approved and reviewed by a registered dietitian in August 2020. The chef and the dietitian have been</p>

<p>service delivery.</p>		<p>working on the high protein diet for residents with unintentional weight loss and increasing the standard of teatime meals.</p> <p>The chef receives resident dietary profiles and is notified of any dietary changes for residents. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. The kitchen is adjacent to the main dining room where residents who are able plate their own meals from the bain marie, otherwise staff plate the meals for the residents. Trays are taken to the resident rooms in hot boxes by healthcare assistants. Special equipment such as lipped plates and built-up spoons are available as needs required.</p> <p>All perishable foods and dry goods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Chemicals were stored safely. Freezer, fridge and end-cooked, reheating, cooling and serving temperatures are taken and recorded daily. Food is probed for temperature prior to going into the hot box or the self-serve bain marie, which was within acceptable ranges. The previous finding has been addressed.</p> <p>The residents interviewed were complimentary of the meals and baking provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP consultation. There is documented evidence in the electronic progress notes and correspondence section of family/whānau contact in each resident file that indicates family were notified of any changes to their relative's health (link 1.1.9.1), including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Short-term care plans were documented for acute needs, however, not all interventions were current.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. An online wound register is maintained. Wound assessments, treatment plans and ongoing evaluations were in place for one hospital resident (skin tear), and five rest home residents (two skin tears, one abrasion, one boil and a chronic wound).</p> <p>Continence products are identified in resident files and include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Paper-based monitoring forms are used for weight, vital signs, blood sugar levels, pain, challenging behaviour, food and fluid charts, and neurological observations.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The social events team is led by an experienced full-time social event manager (qualified diversional therapist), who provides oversight of social events across all sites. She is supported by an assistant (DT) who is employed for 22 hours a week. An activity profile is completed on admission in consultation with the resident/family (as appropriate). Archer uses the tree of life to provide a visual history of the resident's life and uses a 'simply me' tool to identify routines and preferences. Documentation in the resident files was individualised and reflected the specific needs and interests of each resident. In the long-term resident files reviewed, the activity care plans and evaluations were individualised and had been reviewed at least six-monthly.</p> <p>A monthly planner is developed (fortnightly during lockdown periods) which is provided to all residents and displayed on noticeboards. The routine programme includes exercises, newspaper reading (resident led) swimming, group games, physiotherapy ball games. Weekend activities are led by volunteers and staff. Sport on TV is advertised, movies are available, one volunteer provides a song-a-long and group games. Another volunteer plays cards with residents on a Sunday. Church services are held on Sundays. Resident outings include an 'egg run', where staff order free range eggs from Lincoln, and the residents collect the order and distribute the eggs to staff.</p> <p>There is evidence that the residents have input into review of the wider programme. Informal monthly forums are held to reflect on the month, including suggestions to include in the programme for the following month and feedback on activities of lower satisfaction. Formal resident meetings are held bi-monthly, which provides a more structured review of the programme and residents provide feedback of their suggestions, concerns and issues across the departments.</p> <p>Archer Village has endeavoured to maintain the continuous improvement awarded at the certification audit. The annual holiday had to be cancelled due to Covid-19 restrictions. The Phoebe Elizabeth fund is used for resident welfare including going towards the holiday fund. The service continues to fundraise for the fund.</p> <p>During the Covid-19 lockdown the usual social calendar was maintained and enhanced with special afternoon and morning teas for residents. A wellness group was developed which provided a forum for residents to talk about how the lockdown period was affecting them. Zoom and facetime sessions were held for families to keep in touch with residents. Walking group sessions were increased as weather permitted. One resident celebrated a special birthday during the lockdown period. Two tables were set up on either side of the fence, with flowers and balloons, and disposable cutlery and glasses for a socially distanced afternoon tea. The birthday presents were delivered earlier, wiped and presented to the resident so they could open the presents with their family.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery</p>	<p>FA</p>	<p>Initial care plans for long-term residents were evaluated by the registered nurses within three weeks of admission. Overall, the long-term care plans have been evaluated by the RN six monthly or earlier for any</p>

<p>plans are evaluated in a comprehensive and timely manner.</p>		<p>health changes in the electronic resident files reviewed, however, the evaluations were not always in line with interRAI reassessments (link 1.3.3.3). Evaluations reviewed, identified if the resident goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes. Relatives are invited to attend GP reviews (documented in the progress notes), if they are unable to attend, they are updated of the changes as documented in the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a code of compliance which expires 1 February 2021. There is a maintenance person employed to address the reactive and planned maintenance programme. There are gardeners employed to manage the lawns and grounds. The planned maintenance schedule includes electrical testing and tagging, resident equipment checks, calibrations of weigh scales and clinical equipment and testing and tagging of electrical equipment. Monthly hot water tests are completed for resident areas and are below 45 degrees Celsius. Monthly maintenance internal audits are completed. Essential contractors/tradespeople are available 24 hours as required.</p> <p>The facility promotes safe mobility with the use of mobility aids. Residents were observed moving freely around the communal areas with mobility aids where required. The external areas and gardens were well maintained. Outdoor areas had seating and shaded areas available. There is safe access to all communal areas. Healthcare assistants interviewed stated they have adequate equipment to safely deliver care for residents. Residents are able to bring their own possessions into the home and are able to adorn their room as desired.</p> <p>The Port Hills wing has been fully refurbished. The box shelves have been removed, and hi/low hospital beds and ceiling hoists have been installed in all resident rooms. The previous finding from the partial provisional audit has been addressed.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service (9 April 2019). The finding from the partial provisional audit has been addressed. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Fire training and security situations are part of orientation of new staff and include competency assessments. Six monthly fire evacuation practice documentation was sighted with the last evacuation having occurred in July 2020 which included fire warden training. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>Emergency equipment is available at the facility. There are emergency kits and equipment stored centrally in the facility. In the event of a civil defence emergency there are adequate supplies including food, water, blankets and gas cooking. The service has an emergency generator for emergency power and short-term</p>

		back-up power for emergency lighting. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>Infection monitoring is the responsibility of the Infection Control Coordinator (the clinical manager). All infections are entered into the electronic database, which generates a monthly analysis of the data. There is an end of month analysis with any trends identified and corrective actions for infection events above the industry key performance indicators. There are monthly comparisons of data. Outcomes are discussed at the leadership/quality meetings, however, are not documented as discussed with staff (1.2.3.6).</p> <p>There were two outbreaks in 2018, which were managed and documented well, with notifications made in a timely manner.</p> <p>Covid-19 was managed well. Logs were maintained of staff and resident screening. Daily updates with staff were held during handovers. Newsletters were sent to relatives and to residents. A resource folder was maintained with current advice and regulations. The infection control officer has developed a flip chart for staff to access quickly with bullet point instructions to follow during each level of lockdown. Hand hygiene and personal protective competencies were completed. Adequate supplies of PPE and hand sanitisers were sighted.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation of any restraint and enablers would be reviewed through internal audits, RN and facility meetings.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, there were no residents with restraint and no residents using enablers. Healthcare assistants interviewed were able to describe the differences between restraint and enablers.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Seventy percent of relatives in the 2019 satisfaction survey were very satisfied with the way staff consulted around residents' welfare. Sixty-five percent indicated they would like more contact when asked around the frequency Archer home informed them of residents' health status.</p> <p>Relative notifications were not always documented either in the progress notes or on the electronic adverse event forms following incidents. No relatives were available for interview on the day of the audit.</p>	<p>Incident reports for four hospital and one rest home resident did not document relatives were notified following an incident.</p>	<p>Ensure communication with relatives is documented.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the</p>	PA Low	<p>Monthly data is collated around infections and adverse events. The data is entered onto the electronic system, which provides graphs and charts. The data is analysed by the clinical manager for trends, and corrective actions are entered onto the electronic corrective action log. Staff reported data is discussed at</p>	<p>There was no documented evidence of quality data and corrective actions being discussed at the</p>	<p>Ensure discussions held around quality data and corrective</p>

results communicated to service providers and, where appropriate, consumers.		handovers, and graphs are available on noticeboards, however there is no documentation of quality data being discussed at meetings.	leadership/quality and risk meetings, the registered nurse meetings or the staff meetings.	actions are documented in the meeting minutes. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Initial assessments and care plans were developed and reviewed within timeframes. Overall, initial interRAI assessments were completed within expected timeframes, however, not all re-assessments were completed within six months. Long-term care plans had been reviewed when changes in health status occurred (within six months).	Two hospital residents and one rest home resident did not have interRAI reassessments completed within the six-month timeframe	Ensure interRAI assessments are completed within expected timeframes 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Overall, interventions and corresponding monitoring charts were documented. The HCAs interviewed felt there was adequate information in the care plans to guide them to provide a good standard of care. The HCAs reported they are updated of new interventions and changes to resident cares at handovers, however, this is not always documented.	i) One rest home resident did not have interventions documented around the care of a plaster cast, increased care required and pain following a fracture. ii) One hospital resident with challenging behaviours did not have triggers or individualised de-escalation strategies documented in the care plan.	Ensure all current interventions are documented in care plans. 90 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.