

Vinada Limited - Voguehaven Rest Home

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:	Vinada Limited
Premises audited:	Voguehaven Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 December 2020 End date: 15 December 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:	23

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

Voguehaven Rest Home provides rest home level of care for up to 26 residents. On the day of the audit there were 23 residents. The manager has the responsibility of the daily operations and oversee the delivery of services. She is supported by a part-time non-clinical manager, a clinical manager and long serving staff. The residents and a relative interviewed spoke positively about the care and support provided at Voguehaven Rest Home.

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

One of the three shortfalls identified as part of the previous audit have been addressed. This was around first aid cover. There continues to be improvements required around care planning and hot water temperatures.

This audit has identified further requiring improvement around; meetings, internal audit follow up, staff job description, staff orientation, staff training and appraisals, timeframes for resident documentations, resident care interventions, evaluation of care, medication management, and kitchen services.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and a family member interviewed verified ongoing involvement with the community.

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.
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Voguehaven Rest Home has a documented quality and risk programme. Data is collected on complaints, accidents, incidents, infection control and restraint use. There is a quality and strategic plan in place. Resident/relative meetings are held regularly. There are human resources policies including recruitment, job descriptions, selection, orientation, and staff training and development. The service has an annual training plan for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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A registered nurse assesses all resident and documents care plans. Resident files included medical notes by the general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three-monthly. Care staff implement the activity programme for the residents. All meal preparation and baking are undertaken on site in the domestic style kitchen. Residents' food preferences and dietary requirements are identified at admission and accommodated. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The building holds a current warrant of fitness. Emergency and disaster management systems are in place in the event of a fire or external disaster. There are staff on duty 24/7 with a first aid certificate.

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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. No restraints and no enablers were in use.

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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical manager and part-time registered nurse are the infection control coordinators and oversee infection control management for the facility. The clinical manager has completed infection control education and coordinates education and training for staff. Information obtained through surveillance is used to determine infection control activities and education needs within the facility.

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	9	0	1	8	0	0
Criteria	0	34	0	5	9	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the facility manager using a complaints' register. There have been no documented complaints since the last audit. Five residents and one family member advised that they are aware of the complaint procedure.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	There is a policy to guide staff on the process around open disclosure. The manager and clinical manager interviewed confirmed family are kept informed. One relative interviewed stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. The family member interviewed stated they are notified promptly of any changes to residents' health status. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident

conducive to effective communication.		should they wish to do so. There is access to an interpreter service as required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Voguehaven Rest Home is a 26-bed rest home, which provides a homely environment. On the day of audit there were 23 rest home residents. One resident was funded through the long-term chronic conditions contract, all other residents were funded through the ARRC contract. One resident was high needs and bed bound (link 1.3.6.1).</p> <p>The service is privately owned, and the owner is involved in the overall management of the service. There is also a service manager who has been in the role since September 2020 and was previously a senior caregiver at the service. The owner supports the new manager in her role. The owner and new manager expressed a commitment to service review and were implementing a series of improvements at the time of audit (an example includes a review of the quality and internal audit process). The new manager discussed overall service improvement and organisation of processes.</p> <p>There is also a clinical manager who is an RN (four days a week) and has been in the role for two years (link 1.3.6.1). A non-clinical support manager (administration) also works part time. All managers' report to the owner as the overall manager.</p> <p>There is a current quality and strategic plan in place. Goals identified included (but are not limited to) upgrade the accommodation and environment, retain effective staff members, and maintain occupancy above 94%. The plan was in the process of review at the time of audit for 2021.</p> <p>Staff interviewed confirmed the communication levels are good and the staff work together as a team. Residents and a family member interviewed spoke highly of the staff and the services provided.</p> <p>The Voguehaven rest home owner has attended at least eight hours of training relating to the management role. The clinical manager maintains relevant professional development hours. A current annual practicing certificate was sighted.</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</p>	PA Moderate	<p>There are policies and procedures to guide the facility to implement the quality management programme including (but not limited to) quality assurance and risk management programme, management committee responsibilities and internal audit schedule. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys, however there was little evidence to show that meetings are held, quality data followed up on, or action plans documented.</p> <p>Health and safety policies, systems and processes are implemented to manage risk. Staff interviewed stated they are well informed and receive quality and risk management information such as accident incident graphs and infection control statistics.</p> <p>Internal audits are completed as per the annual internal audit schedule but results not always followed up on. The</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>resident satisfaction survey and relative satisfaction survey have been documented as undertaken but not collated or presented.</p> <p>Clinical guidelines are in place to assist care staff with safe and timely delivery of care. Policies and procedures are reviewed regularly and include reference to interRAI assessments where applicable. Falls prevention strategies are in place, that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</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>There is an incident reporting policy that includes definitions and outlines responsibilities. Nine accident/incident forms were reviewed. All document timely registered nurse (RN) review and follow-up when required. There is documented evidence the family had been notified of any incidents. Discussions with the owner confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There has been no notification since the last audit (link 1.3.6.1).</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>PA Moderate</p>	<p>There are human resources policies to support recruitment practices including a job description for each role. Five staff files (one clinical manager and four caregivers) were reviewed. The recruitment and orientation process were not fully evidenced including: Staff job descriptions, orientations and reference checks were not all on files and one staff member with no contract on file.</p> <p>Performance appraisals were documented annually except for the clinical manager. A current practising certificate was sighted for the clinical manager. Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. The clinical manager and caregiver's complete competencies relevant to their role, such as medications and these were current.</p> <p>There is an annual education planner in place that covers compulsory education requirements over a two-year period, however this audit was unable to evidence training for 2020 as no documentation was available. Training around Covid-19 was documented for February with good attendance and covered the DHB plan for Covid -19</p>

		<p>practice.</p> <p>Caregivers are encouraged and supported to undertake external education. The clinical manager has completed interRAI training and has attended education sessions at the district health board (DHB).</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>	FA	<p>Staffing rosters were sighted and there is an adequate number of staff on duty to meet the residents' needs. The clinical manager has been in the role since August 2018 and works 24 hours a week, six hours on Monday, Wednesday, Thursday, and Friday. A part-time RN assists when required.</p> <p>The service manager and the owner are on call 24/7 for any facility or staffing issues and the clinical manager is on-call 24/7 for any clinical issues.</p> <p>There are two caregivers on the morning shift and afternoon shift, there is one caregiver on the night shift. The resident care manager/director and housekeeper are qualified caregivers and can provide assistance when required. There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Residents and the one relative interviewed confirmed that there are sufficient staff on site at all times and staff are approachable and, in their opinion, competent, professional, respectful and friendly.</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>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs and senior caregivers who administer medications complete annual medication competencies. Annual in-service education on medication is provided. Medications are checked on delivery against the medication chart and any discrepancies fed back to the pharmacy. All medications are stored safely. Standing orders are not used. All eye drops were dated on opening. There were no residents self-medicating at the time of audit. Ten medication charts were reviewed. The GP generates handwritten medication charts. All medication charts had photo identification and an allergy status; however, not all charts included 'indications for use' for as needed medication. The GP reviews the medication charts at least three- monthly. The administration signing sheets reviewed did not all identify medications had been administered as prescribed, some residents had more than one medication chart and controlled drugs were not always checked weekly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's</p>	PA Moderate	<p>Meals and baking are prepared on site in the domestic style kitchen. The kitchen was observed to be clean and well maintained, however the cleaning schedule was not always signed as completed and fridge temperatures were not always documented. A dietitian approves the four-seasonal menu. The cook receives resident dietary information including dislikes and food allergies. Any special dietary requirements are delivered in named containers. Residents and a family member interviewed were very complimentary about the meals provided.</p>

<p>individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>Serving temperatures are checked on delivery and recorded. Bulk food and perishable goods were not all date labelled. The service has registered their FCP, but this has not yet been verified. All staff involved in the preparation of breakfasts and serving of meals have attended food safety training.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Four residents had a long-term care plan documented and one had a short-term care plan. Care plans did not always document the required supports/needs to reflect the resident's current health status, this is a continued shortfall from the previous audit. The one relative interviewed confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative involvement in the development of care plans. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, dietitian, and mental health services.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the RN initiates a review and if required, GP consultation. The GP practice expressed concern regarding communication and clinical oversight. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Family notifications are documented on the family contact form in the residents' files reviewed. Adequate dressing supplies were sighted. Wound management policies and procedures are in place, but a wound plan was not documented for one wound. There were no pressure injuries. The service is able to access wound district nurses for advice on wound management. Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used. Not all nursing assessment and interventions have been documented as undertaken.</p>
<p>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</p>	<p>FA</p>	<p>The activities are led by the service manager. Individual assessment and activity plans are documented by the registered nurse. Caregivers also assist with the activities. Activities are planned over seven days a week with caregivers implementing activities over the weekend. There are a variety of recreational activities such as news reading, word games, crafts, quizzes, exercises, daily sing-a-longs, and movies. The activity programme is adapted for special request such as trips to local sights, gardening and knitting clubs.</p> <p>There are entertainers and community visitors including pastoral visitors and school children. There are weekly outings and/or mystery drives. Activities offered are meaningful and meet the residents' recreational preferences. A resident profile is completed soon after admission. Each resident has an individual activity plan which is evaluated monthly. The service receives feedback on activities through one-on-one feedback, residents' meetings, and</p>

service.		surveys. Residents interviewed were happy with the programme provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Four of five initial care plans reviewed were evaluated by an RN within three weeks of admission and a long-term care plan developed. Care plans had not been evaluated six-monthly for four of four long-term resident files reviewed. One resident has not been at the service six months. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.
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	<p>The building has a current building warrant of fitness that expires 1 August 2021. The directors have a reactive and planned maintenance programme in place. The manager, owner and also a part-time maintenance person responsible for the daily maintenance of the facility and the planned maintenance plan. There has been ongoing upgrading of the facility as needed. Hot water temperature checks were conducted and recorded monthly; however, water temperatures have remained over 45 degrees in some resident areas, this is a continued shortfall from the previous audit.</p> <p>An external contractor has serviced medical equipment annually. Electrical equipment has been serviced two yearly. Residents were observed to safely mobilise throughout the facility with easy access to communal areas. There is safe access with ramps and rails to outdoor areas which provide seating and shade. Interviews with staff confirmed there was adequate equipment to provide safe and timely care.</p>
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency and business continuity plans in place to ensure health, civil defence and other emergencies are included. Emergency equipment is available at the facility. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice documentation was sighted. The service has alternative gas facilities (BBQ) for cooking, in the event of a power failure. There is sufficient water stored (well water and bottled water) to ensure ten litres per resident for three days. Most staff have a first aid certificate, and a refresher is booked for other staff. Covid-19 prevented an earlier training. This is an improvement from the previous audit
Standard 3.5:	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in

<p>Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>the facility(link 1.2.3.5). Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks.</p> <p>The service has provided Covid-19 training and all PPE is available as needed. Links to the DHB have ensure that the service has followed best practice. All visitors track and trace and alcolgel is freely available.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Voguehaven rest home has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The resident care manager/director and RN share the restraint coordinator role. The restraint coordinator confirmed that the service promotes a restraint-free environment. There are no residents assessed as requiring restraint or enablers. Enablers in use are voluntary. Restraint education is included in the two-yearly training programme. The caregivers interviewed were knowledgeable in the use of 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)
Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Moderate	Meeting are scheduled monthly to ensure staff communication and to discuss quality data, these have not been documented, with March and November the only meetings able to be evidenced.	Staff / quality meetings and infection control meeting were unable to be evidenced due to lack of meeting minutes.	Ensure that meetings are held according to the schedule and are fully documented 60 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate,	PA Low	Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys, however there was little evidence to show that meetings are held, quality data followed up on, or action plans documented.	The resident satisfaction survey and relative satisfaction survey have been documented as undertaken but not collated or presented.	Ensure that surveys are collated, action plans documented (as needed) and results followed up and communicated. 90 days

consumers.				
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>There is a documented quality plan and process, there are schedules in place for internal audits, including a process for when audit outcomes show a shortfall in service provision. This process has not always been followed.</p>	<p>(i). Monthly medication audits have been completed; however, the last 10 months reviewed identified there was no action plan or robust follow up. Noting, all have documented medication errors with an increasing frequency. (ii). Not all audits documented where shortfalls have been identified had a corrective action plan completed. (iii). Where corrective action plans have been documented these have not been followed up and closed out as completed.</p>	<p>(i). Ensure that issues associated with medication audits have an action plan and evidence follow up. (ii). Ensure that internal audits have an action plan when shortfalls are identified. (iii). Ensure that corrective action plans are follow up on and signed off as completed.</p> <p>60 days</p>
<p>Criterion 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>	<p>PA Low</p>	<p>There are policies in place around staff employment, this includes a job description for each role. Not all staff files had a signed job description.</p>	<p>Four of five staff files (three caregivers and the clinical manager) reviewed did not include a job description.</p>	<p>Ensure each staff member has a signed job description.</p> <p>60 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>The policy around staff employment requires that all new staff have a reference check. This was unable to be evidenced for two new staff members.</p>	<p>Two new staff have no documented reference checks.</p>	<p>Ensure all new staff have documented reference checks as per policy.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an</p>	<p>PA Low</p>	<p>The service has a comprehensive orientation process and template for all new staff. Staff interviewed all agreed that there is a robust</p>	<p>Two new staff have no orientation on file.</p>	<p>Ensure all new staff have a documented orientation to services.</p>

orientation/induction programme that covers the essential components of the service provided.		orientation to services for new staff. Two staff files did not have a completed orientation documented.		90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	There is a documented training schedule over two years that includes all mandatory education for staff. Training for 2020 has not been documented. Service policies include the need for an annual appraisal for all staff , one of five staff members had not documented appraisal in the last year.	(i). The clinical manager's file reviewed does not include a current appraisal (last completed 2018). (ii). Mandatory training was unable to be evidenced for staff in 2020, and therefore this audit was unable to evidence eight hours of training for caregivers for 2020 as per the ARC contract.	<p>(i). Ensure that staff have an annual appraisal documented. (ii). Ensure that the training schedule is implemented, and all staff attend at least eight hours of training pertinent to their role annually.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs and senior caregivers who administer medications complete annual medication competencies.	(i). Two residents have more than one copy of their medication chart in the medication file. (ii). Two residents with regular medication did not have all medications signed as given (or recorded as not given). (iii). Four medication charts had no 'indications for use' for as needed medications. (iv). Weekly controlled drug medications have not been consistently documented.	<p>(i). Ensure that each resident has only one current medication chart. (ii). Ensure that all medication is signed for on administration (or documented as not given with a rationale). (iii). Ensure that medication charts have 'indications for use' for as needed medications. (iv). Ensure that weekly controlled drug medications are consistently documented.</p> <p>30 days</p>

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Moderate</p>	<p>The small domestic kitchen was observed to be clean and well kept. The cook discussed the dietary needs of the residents and how the kitchen makes sure that all resident food preferences and special needs are catered for. The cook was observed assisting with a resident on the day of audit by offering special treats and tea to assist with behaviour management. It was also observed that drinks and snack were available at any time to all residents. Kitchen documentation was not well kept including: a food control plan, fridge temperatures, stock dating and the cleaning schedule.</p>	<p>(i). The cleaning schedule has not been consistently signed off. (ii). Fridge temperature have not been consistently recorded. (iii). Bulk and perishable food are not all dated. (iv). The service has registered their FCP, but this has not yet been verified.</p>	<p>(i). Ensure the cleaning schedule is consistently signed as completed. (ii). Ensure that fridge temperature have are consistently recorded. (iii). Ensure that bulk and perishable food is dated and a stock rotation system in place. (iv). Ensure that a food control plan is verified</p> <p>60 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>There service has a schedule for interRAI assessments. The clinical manager and caregivers explained that much of the resident care is discussed during handovers, however the documentation of assessments and care plans was not timely.</p>	<p>(i). The initial interRAI was not documented within timeframes for two recently admitted residents.</p> <p>(ii). The long-term care plan was not documented within timeframes for one new resident.</p> <p>(iii). Routine (ongoing) interRAI assessments were not completed six-monthly for three residents.</p>	<p>(i)-(iii). Ensure that all assessments are care plan documentation is completed according to timeframes.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the</p>	<p>PA Moderate</p>	<p>All five resident files documented a care plan. This small service has care staff and other staff who have worked with residents over a period of time and it was evident that they were very knowledgeable regarding care needs. Care plans reviewed did not include interventions to support all assessed needs and this is an area that continues to require</p>	<p>Falls interventions were not well documented in one resident file, behaviour management and interventions were not well documented in two resident files. Interventions for the need to monitor blood sugars were not in place for one resident. The high needs resident file did not match their current needs, including moving and</p>	<p>Ensure that care plans reflect the resident need as identified by the assessment process and GP notes.</p> <p>30 days</p>

ongoing assessment process.		improvement.	handling care and the use of an air mattress.	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>There are policies and procedures in place for: post fall follow up, weight management and wound care processes including a template. These processes had not been consistently followed.</p> <p>The service employs an experienced clinical manager who has been in the role for two years, however the feedback from the associated GP practice is that they have concerns regarding the clinical communication and oversight. Additional support from the GP practice has included: assistance with wound dressings and additional support to give injections.</p> <p>There is one resident who requires a higher level of care due to deteriorating health status. The resident is currently bed bound. The clinical manager stated that the DHB were aware of the resident, however there was no notification to HealthCERT. Care staff were able to discuss the care needed for this resident, and care was witnessed to be supportive and caring on the days of audit.</p>	<p>(i). Neurological observations for three residents were not completed as per policy. (ii). One resident with a wound did not have a wound chart and wound documentation was sporadically recorded in the progress notes. (iii). The resident identified with increased needs had not been weighed according to the care plan, and changes in position had not been documented as completed according to timeframes. The resident with increased needs has not been fully assessed to reflect the higher level of care.</p>	<p>(i). Ensure that neurological observations are documented according to set time frames. (ii). Ensure that all wounds are documented according to the policy. (iii). Ensure that all care is documented as provided for all residents. (iv). Ensure a resident with increased needs is reassessed and HealthCERT notified.</p> <p>30 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the</p>	PA Low	<p>There is a process and schedule for the six monthly interRAI and evaluation of care plans. There are policies in place around care plans and time frames for evaluation and review. Progress notes document that resident care is reviewed, however for the four residents who had been at the service for</p>	<p>Formal evaluations of care plans were not documented for four of four long-term residents.</p>	<p>Ensure that there is a documented evaluation of the care plan at least six-monthly.</p> <p>90 days</p>

support and/or intervention, and progress towards meeting the desired outcome.		more than six months, there were no formal, documented evaluations of the care plan.		
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	There is an ongoing maintenance and checking schedule in place and water temperatures are recorded monthly. Temperatures over 45 degrees have not been addressed.	The water temperatures for some shower rooms have continued to register over 45 degrees.	Ensure that the water temperatures are less than 45 degrees in resident areas. 60 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.