

# MA Healthcare Group Limited - Awanui Rest Home

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## 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:** MA HealthCare Group Limited

**Premises audited:** Awanui Rest Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 25 February 2021      End date: 26 February 2021

**Proposed changes to current services (if any):** Nil

**Total beds occupied across all premises included in the audit on the first day of the audit:** 24

# Executive summary of the audit

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## Introduction

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

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

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

Awanui Rest Home is privately owned and operated and provides dementia level of care for up to 24 residents. On the day of the audit there were 24 residents.

This surveillance audit was conducted against a sub-set of the relevant 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, relatives, management, and staff.

The facility manager is experienced in management of health services and is supported by two registered nurses. There are quality systems and processes being implemented. The relatives interviewed spoke positively about the care and support provided.

Shortfalls identified from the previous certification audit around performance appraisals; staff on duty with a first aid certificate; and ensuring that emergency drills are held for staff at least six monthly have been met.

The shortfalls around consent; documentation of Enduring Power of Attorney's; training for staff as per the set dementia standards; and medication remains.

There are new corrective actions identified at this audit related to documentation that family have been informed following an incident; reporting to external authorities; timeliness of documentation of assessments, care plans, and reviews; documentation of interventions; evaluation of care; and to food services.

## Consumer rights

<p>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.</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 system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service.

## Organisational management

<p>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.</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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Awanui Rest Home has an implemented quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards.

Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there are staff on duty at all times to meet needs of residents in the dementia unit. There is an implemented orientation programme that provides new staff with relevant information for safe work practice.

## 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 is responsible for oversight of each stage of service provision. A registered nurse is expected to assess, complete care plans and review residents' needs, outcomes, and goals with resident and/or family input. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Families commented positively on the meals. Snacks are always available.

## 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 has a current warrant of fitness. There is a reactive repairs and maintenance system and a 52-week planned maintenance plan. The outdoor areas are easily accessible and secure for the residents who require this. Seating and shade are provided in all outdoor areas.

## 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 processes are in place. Staff demonstrated knowledge on the restraint use minimisation and safe practice policy and alternative methods that may be used. All staff have received education on challenging behaviour management. The service is a secure facility. There is no restraint and no use of enablers on the days of audit.

## 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.

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated, and reported to relevant personnel. There have been no outbreaks. Staff have implemented processes to manage the Covid-19 pandemic as per changes in levels announced by the Ministry of Health and Public Health services.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	9	0	3	6	0	0
<b>Criteria</b>	0	39	0	4	6	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	<p>PA Moderate</p>	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on three out of five resident files reviewed. Discussions with staff including the facility manager, two registered nurses, five healthcare assistants, diversional therapist, office administrator and cleaner confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. Two resident files did not include an activated EPOA.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	<p>FA</p>	<p>A policy and procedure is attached to every admission agreement and is in line with Right 10 of the Code. The procedure provides details regarding how to make a complaint, who to make a complaint to, and includes contact details, timeframes for responding, and how to access advocacy services.</p> <p>A complaints register is maintained. All complaints are managed by the registered nurses with oversight by the facility manager. A review of the quality process confirmed that the complaints process is integrated with the quality</p>

<p>understood, respected, and upheld.</p>		<p>programme.</p> <p>There has been one anonymous complaint which was investigated by the district health board (DHB). The DHB was not able to substantiate the concerns raised by the complainant and did not progress the complaint. The facility has improved the monitoring of staff, decreased the frequency of falls, and investigated missing residents clothing. A second complaint was forwarded to the service by the Health and Disability Commissioner related to use of social media by a staff member. The service is waiting for closure from the Health and Disability Commissioner.</p> <p>Staff interviewed confirmed their knowledge of the complaints process. Family interviewed confirmed they understand their right to complain.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>PA Moderate</p>	<p>Staff were observed communicating effectively with residents and their families. Open disclosure policies outline the way in which information is to be provided to the residents and families. The information brochure provides a comprehensive range of information regarding the services provided. The admission pack gives comprehensive information regarding the scope of the service including services requiring additional fees.</p> <p>Family are involved in an annual resident's review. There is evidence that informal communication with family members occurs regularly. Access to interpreting services is available but have not been required. Five family members interviewed confirmed they were kept well informed and were encouraged to visit the unit.</p> <p>A review of 28 incident forms and progress notes did not confirm that family were always informed of an incident that their family member had been involved in.</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>Awanui Rest Home is privately owned. The director also owns two other rest homes and relies on the facility manager and registered nurses to inform them of any issues that may arise in this service.</p> <p>The service provides dementia level of care for a total of 24 beds under the aged related residential care agreement. There were 24 residents on the day of the audit. None were under the age of 65 years. One resident had recently been admitted for respite care.</p> <p>The service has a current business plan which identifies the objectives and goals of the service. A mission statement, philosophy, and objectives are in place and reflect a resident centred approach. The core value 'living well with dementia' is stated on the entrance sign.</p> <p>The facility manager has had extensive experience (over 30 years) in managing aged care services including owning an aged care service in the past. The manager has responsibility for operational matters. The manager is supported by two registered nurses (RN) who work a total of 52 hours. The previous registered nurse resigned from the service in December 2020 and the two new RNs have been appointed since that time. One registered nurse was providing casual cover for the previous registered nurse when they were on leave, has been a registered nurse</p>

		<p>working in aged care in New Zealand for five years with 10 years previous experience in the Pacific islands. They have also been a nurse manager for a rest home for three years. The second registered nurse has only been appointed three weeks prior to the audit. They have worked in rest homes for seven years prior to this appointment (link 1.2.4.2). The manager and registered nurses attend over eight hours of professional education a year. The manager's roles and responsibilities are clearly defined in the position description.</p> <p>Interviews with family confirmed that the service meets the high level of care needed for their family members. Management and staff reported sufficient staffing, resourcing, and equipment to provide care.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service has a quality risk management plan in place that is reviewed annually. The service has in place a range of policies and procedures to support service delivery that have been developed by an external consultant. These have been reviewed regularly.</p> <p>The quality programme includes an annual internal audit schedule that has been implemented. Audit summaries and corrective action plans are documented where a noncompliance is identified. Issues and outcomes are reported and discussed at the monthly staff meeting. Corrective action plans reviewed showed documentation of resolution of issues with these closed out in a timely manner.</p> <p>The monthly staff meeting includes discussion around all aspects of the quality programme including incidents, accidents, complaints, health and safety, infection control, clinical issues, staffing, survey results and discussion of improvements. The meeting serves as a forum to review progress towards goals documented in the quality plan. Discussions with the registered nurse, the facility manager and staff confirmed their involvement in the quality programme.</p> <p>There is an annual satisfaction survey with one return for December 2020 already submitted. Results of the 2019 and 2020 surveys to date indicate a high level of satisfaction with the service.</p> <p>The service has a health and safety management system. There are implemented risk management and health and safety policies and procedures in place, including accident and hazard management. Falls prevention strategies are implemented for individual residents, and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. All hazard forms reviewed showed evidence of resolution of issues in a timely manner. The two registered nurses are identified as the health and safety representatives. Both have a job description that describes their role, and both were able to describe this role. There is a hazard register with this is discussed and reviewed at staff meetings.</p>
Standard 1.2.4:	PA Low	Staff document adverse, unplanned or untoward events via the accident/incident forms. The 28 incident and

<p>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>accident forms reviewed confirmed that these are signed off by the facility manager and/or registered nurse with information collated and reported on a monthly basis. There is an open disclosure policy. Not all actions had been taken to monitor a resident if they had an un-witnessed fall or had hit their head while falling (link 1.3.6.1).</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse event reporting (link 1.1.9.1). Family members interviewed confirmed that information provided to them regarding adverse events was in line with the principles of open disclosure. Some incidents had not been reported to external authorities.</p> <p>Samples of incident/accident forms confirmed that data is analysed, and corrective actions implemented. Trends are identified and fed back at staff meetings and handover.</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>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities, and authority. These were reviewed on staff files along with: employment agreements; reference checking; and completed orientations.</p> <p>Copies of current annual practising certificates were sighted for all staff that require them to practice. The facility manager and registered nurses are responsible for the in-service education programme. All staff have received training in challenging behaviour with some completing the dementia care standards (NZQA). Annual education plans were viewed.</p> <p>Staff files provided evidenced that all staff complete an orientation programme. All five staff files reviewed confirmed that they had completed an annual appraisal as per policy. The improvement required at the certification audit has been met.</p> <p>The two registered nurses were completing interRAI training on the day of audit. They will be supervised for the first assessments as they complete these. Kitchen staff have completed safe food handling training.</p> <p>Five of the thirteen healthcare assistants who work in the dementia unit have completed appropriate training in dementia standards and two are currently in training. There are six healthcare assistants who have not completed dementia training as per the contract and the previous improvement required at the certification audit remains.</p>
<p>Standard 1.2.8: Service Provider</p>	<p>FA</p>	<p>Staffing levels are based on the needs of the residents. Staffing levels meet contractual requirements. The facility manager and registered nurse together are responsible for rostering. Rosters reviewed for 2021 confirmed that staff</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>are replaced if on leave. Staff confirmed there are adequate staff on each shift to meet the needs of the residents, and family interviewed stated that there are always staff available to support residents when they come in.</p> <p>Healthcare assistants (HCAs) rostered include AM: three long shifts; PM: two long and one short shift and a tea staff member; and two HCAs overnight.</p> <p>The facility manager, registered nurses, and diversional therapist work Monday to Friday. There are dedicated kitchen, laundry, cleaning, maintenance, and garden staff.</p> <p>A registered nurse is on duty five days a week with 40 hours a week allocated. The two registered nurses alternate and provide on call support. Details of staff rationale and skill mix are documented in policy.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The RN and senior medication competent HCAs administer medications. There has been medication education in 2020 and more is planned for this year. There are shortfalls identified related to medication administration and management and the previous shortfall relating to the documentation of the date on eye ointments remains.</p> <p>Staff have completed training around administration of medication in 2020. Two registered nurse records and two records of HCAs who administered medications were reviewed and all had a current medication competency.</p> <p>The medication fridge temperature is checked daily, and temperatures reviewed were in range as per policy. The ambient temperature are not taken in the medication room to ensure it is below 25 degrees Celsius.</p> <p>Staff sign for the administration of medications electronically. Ten medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids</p>	<p>PA Low</p>	<p>The service has a head cook who works Monday – Friday 0700-1530. There are two other cooks who cover weekends and annual leave. There are no kitchen hands. All cooks have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals are cooked on site.</p> <p>Meals are served in the dining room directly from the kitchen servery. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. Meals were observed to be hot and</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>well-presented, and residents were observed to be enjoying their meal.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily however the temperatures of the freezers were recorded only as 'lo'. Food temperatures are checked, and these were all within safe limits. HCAs serve the evening meal and food temperatures are checked at this time as well.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly. Changes to residents' dietary needs have been communicated to the kitchen as confirmed by documentation on the white board in the kitchen and through interviews with staff including the cook. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by a dietitian. All family members interviewed were satisfied with the meals. Snacks are available at all times.</p> <p>The food control plan has not been reviewed in a timely manner although a date has been set. Covid-19 and periods of lockdown has prevented the auditors from completing a review of the food control plan. Inspection is due shortly on a planned and confirmed date.</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 Moderate</p>	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this.</p> <p>Interventions were not always documented to meet the needs of the resident. Care plans have not always been updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations were not always completed for un-witnessed falls or falls where residents hit their head.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms were described as being documented when these occurred. There were no wounds or pressure injuries on the days of audit.</p> <p>Monitoring forms are in use as applicable such as weight and vital signs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	<p>FA</p>	<p>There is a Diversional Therapist (DT ), who works six hours a day Monday to Friday except for Thursday which is seven hours. On the days of audit residents were observed going for walks, joining in a quiz, and playing games.</p> <p>There is a weekly programme in large print on whiteboards in each wing and some less cognitively impaired residents have a copy in their room. The programme can vary from the printed programme due to residents' mood</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>and fatigue. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music, van outings and walks outside.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>Residents who wish to attend church go out with their families/friends, and spiritual services are offered weekly.</p> <p>There are van outings twice weekly. If it is fine weather, the residents go for walks every day. The DT also takes small groups shopping.</p> <p>Special events such as birthdays, Easter, Anzac Day, and Queens's birthday are recognised and celebrated.</p> <p>There is a chicken run in the garden and residents enjoy going with staff to collect the eggs. Family members bring in their dogs to visit noting that this has waned since Covid-19.</p> <p>The residents enjoy music and singing as observed on the days of audit.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career, and family. Resident files reviewed identified that the 24-hour activity plan is based on this assessment. Activity plans are evaluated at least six-monthly.</p> <p>The DT ensures that there are a range of individual and group activities held each day. The frequent change of activities during the day caters for residents who have a short attention span or for those who have challenging behaviours.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Three care plans reviewed (for residents who had been in the service for a long time) had not been evaluated by the registered nurse six-monthly or when changes to care occurred. Short-term care plans or interventions updated in the long-term care plan were not documented for acute changes in health (link 1.3.6.1).</p> <p>Activities plans are in place for each of the residents and these are evaluated six-monthly.</p> <p>The multidisciplinary review involves the RN, GP, and resident/family if they wish to attend. There have been virtual consultations and evaluation of medical needs during lockdown in the Covid-19 pandemic. There are three monthly reviews by the GP for all residents.</p> <p>Family members interviewed confirmed that they are informed of any changes to the needs of their family member.</p>
<p>Standard 1.4.2:</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 29 November 2021. There is a maintenance</p>

<p>Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>person/gardener who works sixteen hours a week. Contractors are available when required.</p> <p>Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges are carpeted but hallways and bedrooms have vinyl. Corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. There is a large fenced-off garden where residents can roam whenever they like. There is a raised vegetable garden and a chicken run. The separate administration building has the façade of a general store.</p> <p>Staff interviewed stated they have adequate equipment to safely deliver care for dementia level of care residents.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Civil defence kits are kept in a locked shed outside. Review of these confirmed all equipment within its expiry date. The emergency water tank in the garden holds 800 litres. The emergency food supply is sufficient for three days for full occupancy and staffing. There is an emergency gas BBQ provided for cooking. Alternative light source is through large torches. Emergency drills have been held six monthly and the shortfall identified at the previous audit has been met.</p> <p>Staff have completed first aid training and there is always a staff member on site with a current first aid certificate. The shortfall identified at the previous audit has been met.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>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 the facility. Infection control data including trends is discussed with the facility manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks since the previous audit. There has been training around Covid 19 and implementation of the pandemic plan. There is sufficient PPE on site for at least two weeks should there be an outbreak of Covid 19 or other.</p>
<p>Standard 2.1.1: Restraint</p>	FA	<p>The restraint coordinator is the RN. Processes for minimising restraint use and safe practice are in place. Types of authorised restraint are bedrails and lap belts, but these are not used for any resident in the service. The facility</p>



<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>manager and registered nurses are focused on maintaining a restraint-free service noting that the service is a secure facility with environmental restraint in the form of high fencing hidden by gardens. There is a locked coded gate, where family go in and out as they please. Annual restraint minimisation training for all staff was completed and records of training were sighted. Restraint competencies for all staff were current.</p>
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## 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 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	<p>PA</p> <p>Moderate</p>	<p>Signed informed consents and advanced directives were evident in three out of five files sampled. EPOAs were activated on three out of five files. The shortfall identified at the previous certification audit remains. The rating has remained the same, however the timeframe to address the shortfall has been raised to 60 days.</p>	<p>(i) Two out five resident records did not have a signed consent form.</p> <p>(ii) Two out of five resident files did not include evidence of an EPOA.</p>	<p>(i) Ensure all residents have a consent form signed.</p> <p>(ii) Ensure all residents have an EPOA.</p> <p>30 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a</p>	<p>PA</p> <p>Moderate</p>	<p>Two of the 28 incident forms reviewed showed documentation to confirm that family were</p>	<p>Of the 28 incident forms reviewed, 26 did not document evidence that family were informed of</p>	<p>Ensure that family are</p>

right to full and frank information and open disclosure from service providers.		informed of an incident that involved their family member. Staff stated that some incidents would not have been required to be escalated to family as they involved challenging behaviour that the family were aware of, however this was not documented.	an incident that involved their family member.	informed of an incident involving their family member.  60 days
Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.	PA Low	The facility manager understands the statutory and regulatory obligations in relation to essential notifications to the correct authority, however not all incidents that require reporting have been reported using a Section 31 to an external authority. These included a call to police on a number of occasions for a resident who absconded from the premises prior to a reassessment. The change in registered nurse as providing clinical oversight had not been reported.	Not all incidents that required this, and changes in management (clinical oversight) had been reported to the Ministry of Health on a Section 31 form.	Ensure that incidents that are required to be reported, and changes in management are reported to the Ministry of Health on a Section 31 form.  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	Six of the thirteen healthcare assistants who work in the dementia unit have completed appropriate training in dementia standards and two are in training. Six healthcare assistants have been in the service for more than six months and have not yet been enrolled or have not completed dementia training as per contractual specifications. Staff interviewed described senior staff role modelling good practice and practice as per policy.	Six of the thirteen healthcare assistants who work in the dementia unit have not completed appropriate training in dementia standards and they are not enrolled in the programme. The shortfall identified at the certification audit remains, however the rating and timeframe remains the same as training has at times been delayed because of Covid-19.	Ensure that all staff who have been employed in the service for longer than six months are enrolled in or have completed dementia training against set

				standards.  60 days
<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>	<p>PA Moderate</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management. The facility uses an electronic and robotic pack system. There is only one eye drop currently being administered and this has not been dated when opened. The shortfall identified at the previous audit remains.</p> <p>Other shortfalls related to an impress system being used; glucogen in the kitchen fridge not secured safely, put in a dirty container and not labelled; bottles of liquid medicine for a named resident used for another resident as their medicine had run out; documentation of medication to be administered for a resident requiring respite care only documented in the progress notes as being administered (with no administration sheet completed); no hand hygiene used by the HCA administering medication during the medication round.</p>	<p>(i) Eye drops are not dated when opened.</p> <p>(ii) The service does not provide hospital level care but has impress stock with a number of stock medicines being uses.</p> <p>(iii) Medicines in the kitchen fridge were not stored correctly or appropriately.</p> <p>(iv) A single bottle of liquid medication was used for another resident on two occasions.</p> <p>(v) Documentation of administration of medications for a respite resident was not appropriate with this documented only in the progress notes as being taken.</p> <p>(vi) The HCA administering medication did not wash their hands or use hand sanitiser between administering medication to each resident.</p> <p>(vii) The ambient temperature of the room where medication is stored is not taken.</p>	<p>(i) Date eye drops when opened.</p> <p>(ii) Cease using an impress stock system of medication.</p> <p>(iii) Store medicines that require cold storage correctly and appropriately.</p> <p>(iv) Administer medicines to the person for whom it is prescribed.</p> <p>(v) Document administration of medications for a respite resident as per policy.</p> <p>(vi) Ensure staff maintain hand hygiene</p>

				<p>while administering medication.</p> <p>(vii) Record the ambient temperature of the room where medication is stored to ensure that it remains at 25 degrees Celsius or less unless refrigerated.</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>Fridge and freezer temperatures are taken daily. Fridge temperatures are taken, and any adjustments made if required. Freezer temperatures are recorded as 'lo' as per the reading on the thermometer. Actual temperatures are not recorded.</p>	<p>Actual temperatures for the freezers are not recorded.</p>	<p>Record actual temperatures of each freezer and resolve any corrective actions if these are identified.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment,</p>	PA Moderate	<p>The two RNs have only been in the service for a short time (one since December 2020 and one for three weeks prior to the audit). One works 20 hours a week and the other works 32 hours a week. Both were completing interRAI training on</p>	<p>Assessments, care plans and evaluations/reviews of care plans are not always consistently completed in a timely manner as follows:</p>	<p>(i)-(iv) Ensure that assessments, care plans and</p>

<p>planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>the first day of audit. Both registered nurses understood the need for clinical documentation to be completed in a timely manner as per policy with registered nurses stating that they had been trying to catch up on some but noted that they had been unable to complete the interRAI training prior to the one on the day of audit.</p>	<p>(i) One resident file did not include an initial interRAI assessment.  (ii) Three of five resident files did not include a current interRAI (one was last completed in January 2020 and one in September 2019).  (iii) One resident file did not have an initial care plan.  (iv) Evaluations of the care plan were not completed six-monthly in three of four long term files.</p>	<p>evaluations of care plans are consistently completed in a timely manner and as per the ARC contract.  90 days</p>
<p>Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Low</p>	<p>The RNs are expected to document at least weekly in the resident notes or as changes occur. Records reviewed showed the following documentation in the notes by a registered nurse with examples as follows: File 1) Documentation on 14, 15, 20, 21, 31 of January and on the 3 and 17 February; File 2) Single entries in December 2019, April, July (two), October, November 2020, and February 2021; File 3) A three-month gap in documentation from March to June 2020.  The new RNs have started to document at least weekly notes and have documented changes in care in the last two months for some residents.</p>	<p>The registered nurse has not documented a weekly progress note or review in each resident's file or documented changes in state for the resident when these have occurred</p>	<p>Ensure that the registered nurse completes a record of care for each resident at least weekly and as changes occur  90 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers'</p>	<p>PA Moderate</p>	<p>Five resident files were reviewed. Some interventions were described with sufficient information to manage the cares required with examples as follows: (i) One resident had a rash and an eye infection. The doctor prescribed an antiviral medication and there was evidence that this had been take as prescribed. Staff also informed the doctor when the residents condition</p>	<p>(i) Three of five care plans reviewed included a lack of documentation of interventions to address specific cares required (eg, pain in the head and neck for one resident, behavioural management for a second resident, weight loss for a third resident that had occurred when the resident was in hospital [noting that the resident had gained weight since their return although</p>	<p>(i) Document and update interventions to ensure that staff can consistently meet the residents</p>

<p>assessed needs, and desired outcomes.</p>		<p>deteriorated in a timely manner. The resident was admitted to hospital for overnight investigation. (ii) One resident fell and hit their head. The neurological observations taken were abnormal and the ambulance was immediately called.</p> <p>Neurological observations are required to be taken for a resident who has an un-witnessed fall or hits their head. These were not consistently taken as per policy in five of the six incident forms reviewed where the resident had an un-witnessed fall. Staff noted that often the resident would not allow them to take regular observations, however this was not recorded, and the documentation did not evidence observations of the resident as per timeframes in policy.</p>	<p>interventions were not specifically documented], and a resident with a rash on return from hospital noting that the hospital discharge summary contained some instructions but these were not updated to the care plan).</p> <p>(ii) Neurological observations were not taken as per policy in five of the six incidents reviewed where the resident had an un-witnessed fall.</p>	<p>assessed needs or that would contribute to meeting desired outcomes.</p> <p>(ii) Take neurological observations or record observations of the resident within timeframes documented in policy for a resident who has an un-witnessed fall or who hits their head.</p> <p>90 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards</p>	<p>PA Low</p>	<p>Evaluation of care plans has not occurred in files reviewed. Short-term care plans were not sighted as being documented for short-term cares</p>	<p>Evaluation of each care plan has not occurred.</p>	<p>Ensure there is a documented evaluation of each care plan</p> <p>90 days</p>

meeting the desired outcome.				
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.