Henrikwest Management Limited - Craigweil House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Henrikwest Management Limited
Premises audited:	Craigweil House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 June 2021 End date: 17 June 2021

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: 54

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Craigweil House provides rest home, hospital and geriatric level care as well as dementia (memory loss) care for up to 68 residents. The service is operated by Henrikwest Management Limited who own two other aged care facilities. Craigweil House is managed by a facility manager with support from a regional manager and general manager. The facility manager, who is a registered nurse, is currently overseeing all clinical matters with support from a clinical nurse lead.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, managers, staff, a general practitioner (GP) and a visiting podiatrist. Pursuant to a request by the Ministry of Health (MOH) in March 2021, specific investigations were carried out in relation to areas of concern raised by family complainants. These related to the external environment, bathroom facilities and air temperature/ventilation, food services and management of complaints.

This audit resulted in three areas identified for improvement which were related to complaints management, the provision of registered nurses and reconciliation of controlled medicines.

Consumer rights

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

Residents and families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents, and families is promoted and was confirmed to be effective. There are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents.

The residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The service has linkages with a range of specialist health care providers in the community.

Complaints and concerns are acted on.

Organisational management

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

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Annual goals are set and reviewed regularly. Service monitoring is regular and reliably reported to the governing body. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures that support service delivery, were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix aim to meet the changing needs of residents.

Residents' information is kept securely with all entries legible and designated.

Continuum of service delivery

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

Policies and procedures provide documented guidelines for access to service. Residents are assessed before entry to the service to confirm the level of care required. The nursing team is responsible for the assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs and routines. Interventions are appropriate and evaluated in a timely manner. There is a contracted physiotherapist who reviews residents once a week.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activities are managed by a registered diversional therapist and are conducted separately in the hospital, rest home, and memory care unit, respectively.

There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP) and these were current. Staff involved in medication administration are assessed as competent to do so.

The food service provides and caters to residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours a day.

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.

Waste and hazardous substances are well-managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. Two residents were using enablers and three residents were using restraint at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests.

Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes and are provided regular education.

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 management system minimises the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating the education and training of staff. Infection data is collated monthly, analysed, and reported during staff meetings.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service and are carried out as specified in the infection control programme.

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	47	0	0	3	0	0
Criteria	0	98	0	0	3	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Craigweil House has policies and procedures to meet its obligations as defined in the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training was verified in the training records. The Code is displayed around the facility and provided to residents and family/whanau as part of the admission process.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled verified that informed consent had been gained appropriately using the organisation's standard consent form. These are signed by competent residents or the enduring power of attorney (EPOA). The GP makes a clinically based decision on resuscitation authorisation of residents deemed not competent. Sampled files evidenced signed resuscitation decisions and advance directives by residents who are deemed competent. The FM reported that residents were informed about advance directives from admission and on an ongoing basis. All residents admitted to the memory care unit had EPOAs activated. Staff was observed to gain consent for day-to-day care. Interviews with relatives confirmed the service

		actively involves them in decisions that affect their family members' lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Policies and procedures require that residents be informed of their right to access independent advocates. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents interviewed confirmed that they understand these rights and their entitlement to have the support person of their choice available if they choose.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents were assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Family/whānau or friends were encouraged to visit or call. The facility has unrestricted visiting hours (unless restrictions are required due to the current Covid-19 pandemic national alert level). Family members interviewed stated they felt welcome when they visited and were comfortable in their encounters with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Moderate	The MoH requested specific feedback on this standard as it had been identified as an area of concern. The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed said they understood the process. Complaint/compliment forms are readily available and on display within the home. The facility manager (FM) is responsible for complaints management and follow up. Staff interviewed demonstrated understanding of the complaint process and said they refer complainants to the FM and/or to complete a complaint form. Those residents who are able to attend bi-monthly meetings are offered opportunities to raise issues and discuss concerns. Concerns expressed are recorded in the meeting minutes, and entered into the minor complaints book. There was evidence the FM follows these up as soon as practicable and within a reasonable timeframe. In most cases these matters were addressed by notifying staff via written memos which were stapled into the communication diaries. These were also discussed at monthly staff meetings. Documents reviewed and interviews with management, staff, residents and relatives identified that improvements in the management of complaints was required.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Policies are in place to guide staff actions and ensure residents` rights are discussed. The Code was displayed throughout the facility and is available in Te reo Māori and English languages. Information about the Code is provided in the admission pack and included in the resident agreement. Family members and residents interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process. The Nationwide Health and Disability Advocacy Service poster and pamphlets were also displayed. Residents' agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There is a policy and procedure regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms, and reporting requirements. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice. Residents' privacy and dignity are respected. Staff was observed maintaining privacy. A contracted physiotherapist (PT) visits every Monday to conduct the physiotherapy programme with help from the staff. Residents are supported to maintain their independence during the provision of activities of daily living and engaging in active exercises. Residents from the rest home and hospital areas were able to move freely into the surrounding areas and in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values, and beliefs had been identified, documented, and incorporated into their care plan.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The required policies on cultural appropriateness were documented. Policies refer to the Treaty of Waitangi and partnership principles. Assessments and care plans document any cultural/spiritual needs. There was one resident who identified as Maori, and the person's cultural needs were addressed in the care plan. In the interview conducted, the family/whanau and resident confirmed that all their cultural needs were met. Special consideration to cultural needs is provided in the event of death. The required activities and blessings were conducted. All staff received cultural training annually.
Standard 1.1.6: Recognition And Respect Of The Individual's	FA	Family members were interviewed to confirm that the resident's values and beliefs are actively recognised and well supported. This was confirmed by residents and through observations of interactions

Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		between staff and residents during the audit. Values and beliefs were discussed and incorporated into the care plan. The family members interviewed gave examples of being actively involved in any changes in routine for their family member. Staff interviewed were able to describe how each resident can make choices around activities of daily living and activities. Residents on the days of the audit were observed to actively engage in activities of their choice.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Craigweil House has a policy on discrimination in place. This includes guidelines for staff regarding the prevention, identification, and management of discrimination, harassment, and exploitation. The facility manager (FM) reported that the rights of the individuals were protected, and interventions occur to ensure a balance between the personal rights of the individual and others living and working in the facility. All family members interviewed reported that they believed their family members were always safe. Staff receives training on professional boundaries and the Code of Conduct. The Code of Conduct is embedded in the employment agreement and is signed by each staff member on entry to the service. Situations that constitute misconduct are included in staff employment agreements. There were documented complaints of alleged episodes of abuse and neglect (Refer 1.1.13.1).
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through the ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed promptness and appropriateness of medical intervention when medical requests are sought. Staff reported they receive management support for external education and access their professional networks to support contemporary good practice.15 health care assistants (HCAs) have either level two, three, and four New Zealand Qualification Authority (NZQA) qualifications. 11, HCAs were either progressing or yet to begin level two. The FM is a trained Careerforce assessor. All family members interviewed stated that each resident received good care and support with staff conscious of managing all residents' identified needs effectively.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	There was evidence that the service adheres to the practice of open disclosure. The FM reported that all adverse events were managed in an open manner, and these were put in the context of quality improvement. This was evident in the incident forms completed and interviews with family members and residents.

conducive to effective communication.		Access to interpreter services is available through the district health board if required. At the time of the audit, there were no residents who required an interpreter. Staff was observed to engage with residents in a way that involves them as much as possible. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic, quality and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and goals. These goals are monitored for progress in various ways. A sample of monthly reports to the board of directors/owners and management meeting minutes, confirmed there was regular monitoring of service provision. This included occupancy, financial performance, quality data, emerging risks and issues. The management group, two sister facilities and the director/owners also engage in regular group discussions. The on-site service is managed by an RN/ facility manager who is overseeing all clinical care with the assistance of a clinical nurse lead. Both hold up to date annual nursing registrations and have qualifications for their roles. The facility manager was appointed in November 2018 and has previous experience managing aged care facilities. The clinical lead was appointed in February 2021 following the resignation of the previous clinical nurse manager. Two other members of the management team are the office manager and the facility coordinator. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager (FM) reports to the general manager daily. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at aged care education days covering both clinical and management issues. Craigweil House has an Age-Related Residential Care contract (ARCC) with Waitematā District Health Board (WDHB) for respite, hospital and rest home level care including dementia and Long term Support-Chronic Health Conditions (LTS-CHC) and a contract with the Ministry of Health (MoH) for under 65 year olds. At the time of audit 54 of the 68 beds were occupied by residents receiving services under the ARC contract. Thirteen residents were receiving dementia level care, 22 had been assessed as hospital level care, and 19 at rest home level care, which included four short term/respite residents. On the first day of audit two rest home residents were off site in the public hospital. One resident returned at the end of day one having been reassessed as requiring hospital level care. Actions were implemented to accommodate the increased needs of that resident. For example, a change of bed, review and alteration to the resident's plan of care. Also of note, was that two of the respite residents had been waiting more than five months to be reassessed for long term care by the needs assessment and service coordination

		agency. No residents were receiving care under the WDHB Long Term Support-Chronic Health Condition contract or the MoH Non-Aged contract.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The managing director stated that a facility manager from one of the other aged care facilities owned by the group, is delegated responsibility for managing Craigweil House during any temporary absence. This had occurred recently and there were varying accounts from staff about the effectiveness of this arrangement. Evidence could not be substantiated due to time constraints and without the risk of breaching staff confidentiality.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, regular resident, family and staff satisfaction surveys, monitoring of outcomes, clinical incidents including infections, wound care, bruising, falls, skin tears, medication errors and pressure injuries. A range of meeting minutes confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, daily reporting to the general manager and staff meetings. A monthly quality analysis report is shared across all levels of the service which showed positive or negative trending. Documented corrective action plans were developed and implemented to address any shortfalls. Staff reported their involvement in quality and risk management activities through implementation of corrective actions. Consumer participation occurs through annual resident and family satisfaction surveys. The most recent surveys (June 2020 residents and August 2020 family) had low return rates. For example, seven of 48 residents and three family members. Feedback from these was taken into account and actions carried out to address issues. For example, residents' comments resulted in a memo to staff about always knocking on residents' doors before entering and an education session on privacy and dignity occurred. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete

		documents. The general manager and facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Health and safety issues, including newly identified hazards, are documented and reviewed at regular health and safety meetings and discussed at staff meetings. This was confirmed in meeting minutes sighted. Work related staff injuries are reported, none of which required reporting to Worksafe New Zealand. There was a current risk management plan and hazard register. These were reviewed annually by the management group. The facility manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the members of the senior management group. Neurological observations were reliably undertaken for unwitnessed falls and short term care plans are commenced for wound care, as confirmed in residents' files sighted. Incidents and accidents were being evaluated monthly and comparative data trended. These were being reported and discussed at monthly staff and RN meetings. Where unwanted trends were identified corrective action were implemented. The facility manager described essential notification reporting requirements, including for pressure injuries. Records revealed there have been 85 section 31 notifications of significant events made to the Ministry of Health since the June 2019 surveillance audit. Seventy five of these (from January 2020) related to no RN coverage for shifts, eight were for pressure injuries and two for sudden deaths. All of the pressure injuries were identified as not being facility acquired. Neither of the sudden deaths resulted in coroner investigations. Refer to corrective actions in criterion 1.2.8.1 related to RN shortages.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Those interviewed reported that the orientation process prepared them well for their role. Staff records contained documentation of completed orientation and showed that competency assessments occur before solo work is permitted.

		Annual performance appraisals were occurring when due. Staff interviewed were satisfied with the frequency and quality of training provided. Relevant and reliable in-service education was occurring according to the annual training plan which included mandatory training subjects. For example, emergency preparedness, infection control and consumer rights. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. From the fifty care staff employed, nine health care assistants (HCAs) have achieved level 4, one was at level three, five were at level two and eleven were either progressing or yet to begin level two. The facility manager is the internal assessor for the programme. Rosters showed that only staff who had completed or were progressing specific dementia education were rostered for work in the memory unit. Eight staff had completed the level 4 limited career pathways (LCP) dementia modules and four were progressing these. Of the four registered nurses RNs employed (which includes the FM), two were maintaining their annual competency requirements to undertake interRAI assessments. This was confirmed by their personnel records. One more RN is enrolled to undertake interRAI training this year.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility aims to ensure there are enough sufficiently trained staff on site to meet the changing needs of residents. The FM and the clinical nurse lead alternate being on call after-hours. Evening and night staff said they can access advice when needed. The FM/RN lives locally and can be on site within three minutes if required. Care staff reported there were enough HCAs rostered on to complete the work allocated to them. Cleaners, laundry and kitchen staff also confirmed this. There were insufficient RNs employed to cover all shifts 24 hours a day and there is a vacancy for an experienced clinical nurse manger. A newly graduated RN is appointed as Clinical Nurse Lead. This person was the afternoon shift RN during the days of audit and the FM was the RN on the floor for morning shifts Monday to Friday. When there is no RN available, an experienced level 4 HCA is rostered on with the FM or clinical nurse lead on call. See corrective action in criterion 1.2.8.1. Observations and review of a four-week roster cycle confirmed at least one staff member on duty has a current first aid certificate and that only staff who have completed or are progressing the required dementia education are rostered to work in the memory unit. Staffing levels are as follows; Hospital day shift for 23 residents, had four HCAs who start at 8am and a senior HCA from 7.45am. Three finish at 4pm and two finish at 1pm and 2.30 pm. Monday to Friday the FM is the RN on duty. Another RN is rostered on for day shift in the weekends. There are two HCAs allocated (7.45 to 4pm and

		8am to 2pm) for 19 rest home residents, and two HCAs (7.45 to 4pm and 8am to 4pm) for 13 residents in the memory unit. Afternoon shift had one RN from 3.45 to 12pm. There were three HCAs in the hospital (two from 4pm to 12 midnight and one from 4pm to 9pm); two HCAs for rest home (3.45pm to 12 midnight and 4pm to 7pm); and two HCAs in the memory unit (3.45/4pm to 12 midnight). Night shift: One RN 11.45pm to 8am and four HCAs 12 midnight to 8am, two in the hospital and one each in the rest home and the memory unit. The memory unit HCA is relieved for breaks by the night shift RN. A facility coordinator is employed Monday to Friday for various tasks, including accompanying residents to appointments. An office manager assists with employment and rosters across three sites. Two cleaners are on site for 6.5 hours a day seven days a week, and one laundry person for 6.5 hours seven days a week. The DT is employed for 40 hours per week and splits this time to cover weekends as needed. Cooks and kitchen hands cover all meal services seven days a week. For example, one kitchen hand for 7.5 hours and one cook for eight hours each day. A maintenance person is on site two days a week and/or as required. The general manager is available 24 hours a day if required and visits the facility on a regular basis.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents' records are held both electronically and paper-based. The staff have individual passwords to the residents' records database, such as the medication management system and on the interRAI assessment tool. The visiting GP and allied health providers also have access to the system which supports the integration of residents' records. All hard copies were kept securely in the locked cupboards and archive room. Hard copy archived records are stored safely and securely on-site. There is an effective system for retrieving both hard copies and electronically stored residents' records. All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent,	FA	Craigweil House's entry to service policy includes all the required aspects on the management of inquiries and entry. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the family/whānau of choice where appropriate, local communities, and referral agencies. Completed Needs Assessment

equitable, timely, and respectful manner, when their need for services has been identified.		and Service Coordination (NASC) authorisation forms for the memory care unit, rest home, and hospital level of care residents were sighted. Residents in the memory care unit were admitted with consent from EPOAs and documents sighted verified that EPOAs consented to referral to specialist services. Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. The family/whānau interviewed confirmed that they received sufficient information regarding the services provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge, or transfer is managed in a planned and coordinated manner, with an escort/family member as appropriate. There is a documented process in place and open communication between all services, the resident, and the family. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident. The service uses the DHB's ('yellow envelope') system to facilitate the transfer of residents to and from acute care services. All referrals are recorded in the progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Indications for use are noted for 'as required' medications, allergies are indicated, and photos were current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. The medication and associated documentation are in place. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from the hospital or any external appointments. The RNs check medicines against the prescription, and these were updated on the pharmacy delivery forms. The GP completes three monthly reviews. Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal were reported and attended to promptly. Monitoring of three medication room temperatures was maintained. The health care assistant was observed administering medications safely and correctly. Medications were stored safely and securely in the trollies and locked storerooms. Medication competencies were completed annually for all staff administering medication. Medication audits are conducted weekly and corrective action plans were sighted, There were no residents self-administering medications. There is a policy and procedure for self-administration of medication if required. Outcomes of pro re nata (PRN) were documented. An improvement relating to consistently completing six-monthly controlled drugs (CD) stock takes is required.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The kitchen service complies with current food safety legislation and guidelines. There is an approved food control plan for the service which expires 15 July 2021. Meal services are prepared on-site and served in the respective dining areas. The menu has been reviewed by a registered dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents' weights are monitored regularly, and supplements provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night when required. The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers are maintained. Food is transported in a hot cart box to the respective dining areas. The cook reported that there are microwaves in each wing which are used to warm up any cold food and all care staff were aware of this. This was verified in interviews conducted. All these processes were being consistently monitored for effectiveness in addressing previous complaints. The residents and family/whānau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The FM reported that all residents who were declined entry were documented. When a resident is declined entry, family/whānau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a	FA	Residents' level of care is identified through the needs assessment process by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' long-term care plans and interRAI were completed within three weeks, according to policy. Assessments and care plans were detailed and included input from the family, residents, and other health team members as appropriate. Additional assessments were completed according to the need (e.g., behavioural, nutritional,

timely manner.		falls, continence, and skin and pressure risk assessments). The RNs utilise standardised risk assessment tools on admission. In interviews conducted, family member representatives and residents expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The outcome findings from interRAI assessments and input from residents and/or family/whānau inform the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident-focused and individualised. Short-term care plans sampled contained a problem list, goal, intervention, evaluation, and completion date, and were appropriate for the identified problem. Residents in the memory care unit had twenty-four-hour activities care plans in place. Behaviour management plans identifying triggers and interventions were implemented as required. A Maori health care plan prepared for a resident who identified as Maori was in place. Family and residents confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapists, occupational therapists, district nurses, dietitians, and GPs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders were carried out. Wound assessment and wound care plans were being completed and evidence of this was sighted in files sampled. All residents with weight issues had short-term care plans in place with detailed interventions. To address previous complaints and also as a way of managing residents with weight issues. Food and fluid intake charts were completed, nutritional supplements were given, and weight was monitored. Evidence of this was sighted in files reviewed. Referrals to dietitians were completed in a timely manner. The FM reported that the GP's medical input was sought within an appropriate timeframe that medical orders were followed, and care was person-centred. This was confirmed by the GP during the interview. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources were available, suited to the levels of care provided based on the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a	FA	Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by the registered diversional therapist (DT) from Monday to Saturday in all residents' respective units. The other vacant post for a DT was currently under recruitment. There is a student volunteer who comes to assist every Thursday. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays

consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		are celebrated. A resident profile is completed for each resident within two weeks of admission in consultation with the family. The activity programme is formulated by the activities staff. The activities are varied and appropriate for people living with dementia, rest home, and hospital level of care. Residents' activities care plans were evaluated every six months, progress notes are completed monthly and attendance checklist daily. Twenty-four-hour activity plans reflected residents' preferred activities of choice and were evaluated every six months or as necessary. The residents were observed participating in a variety of activities on the audit days. The planned activities and community connections were suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family members and residents reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is documented on each shift by care staff in the progress notes. All noted changes by the care staff were reported to the nursing team in a timely manner. Formal care plan evaluations, following reassessment to measure the degree of a resident's response about desired outcomes and goals, occur every six months or sooner if residents' needs change. The evaluations are carried out by the RNs in conjunction with family, residents, GP, and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan. Short-term care plans were reviewed regularly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family members were included and informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents and family/whānau are supported to access or seek a referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP and the nursing team refers to specialist service providers and the DHB. Referrals are followed up regularly by the GP. The resident and the family were kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to, and the resident transferred to the public hospital in an ambulance if required.

Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow proven to be effective processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. The chemical supply company visits regularly to test the effectiveness of their products and provides hands on training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There were sufficient supplies of protective clothing and equipment available on site and staff were observed using this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The MoH requested specific feedback on this standard as the external environment had been identified as an area of concern. A current building warrant of fitness (expiry date 08 February 2022) is publicly displayed. There have been no changes to the building footprint since the previous audit. The front facing building of Craigweil House is an historic villa with a small covered veranda at the main entrance. This part of the building houses the rest home bedrooms, communal lounge and dining room, kitchen and offices. The hospital wing follows the same roof line and extends north to south forming a back boundary. The purpose built memory unit is the newest building and joined to the hospital wing via a covered deck. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Daily efforts were being made to ensure the environment was hazard free, and that resident's safety and independence was promoted. There is a sufficient number of safe and suitable hoists on site for the number of hospital level care residents. Staff and residents knew the processes for requesting repairs and review of the maintenance book revealed that actions are carried out in a timely way. The wooden ramp and decking outside the memory unit and hospital were littered with leaves and spots of moss on day one, and this was remedied by the end of the day. On inspection the only unsafe reportedly 'rotting' decking was inaccessible to residents. The general manager stated this would be removed during a planned reconfiguration of that side of the building. Architectural planning had started to replace a number of the rest home bedrooms with larger bedrooms that had ensuite bathrooms. Residents in the memory unit have access to a small outside deck and garden areas with plastic chairs, outdoor tables and suitable fencing. Two incidents of residents exiting this area via a wooden gate were reported in early 2021, the gate has since been made secure. The operator said they were considering redesigning the garden area. Staff reported they accompany memory unit residents when they are

		outside and that sun umbrellas are used for shade in the summer. Rest home and hospital residents have easy access to either of the two internal 'sun' lounges. One in the rest home and the other in the hospital wing which opens on to a deck. There is also an internal courtyard from the rest home lounge which had plenty of outside plastic chairs. Staff reported that sunshades are put up in the summer when the space is used for outdoor dining or celebrations. It is unlikely that less mobile residents could use the two barbeque tables situated on a large lawn area, but other chairs/furniture can be accessed for resident seating. One resident regularly tends to the border gardens. The grounds provided are not naturally inviting for wandering or resting in, but they did not pose any obvious risks to resident safety.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	The MoH requested specific feedback on this standard as the state of a one bathroom and residents using other residents' ensuite bathrooms had been reported as an area of concern. Rest home residents have ready access from their bedrooms to two shower rooms with toilets plus two other toilets. One of these bathrooms was causing flooding and was decommissioned for a period of time until repairs could occur. During that time staff were advising or supporting residents to use one of the hospital ensuite bathrooms which could be accessed from a hallway, thus avoiding having to enter a resident's bedroom. This situation is now remedied. The hospital wing has 10 ensuite bathrooms situated between two bedrooms and shared by the residents who occupy those bedrooms. All bathrooms and toilets have functional locking systems for privacy and signs to indicate it they are vacant or occupied. Fifty eight of the sixty bedrooms have hand basins. Appropriately secured and approved handrails are provided in the toilet/shower areas. There were four shower rooms with toilets in the memory unit for a maximum of twenty residents. Records of hot water temperature monitoring showed that hot water accessible to residents was no hotter than 45 degrees Celsius. A designated staff and visitors toilet is in the main building and in the memory unit.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the	FA	All bedrooms in the memory unit are for single occupancy. Of the sixty bedrooms in the rest home and hospital areas, eight rooms had previously been approved as large enough to accommodate a couple. There was one couple who were both assessed as rest home level of care, sharing a bedroom on the days of audit. Rooms are personalised with furnishings, photos and other personal items displayed. The hospital designated rooms have double doors and are of sufficient size to accommodate hoists and other mobility equipment.

consumer group and setting.		Staff have reported frustration with the size of some rest home bedrooms. These were narrow but easily accommodated a single bed, bedside table, easy chair and wardrobe. There are plans to reconfigure one side of the rest home bedrooms and create larger rooms with ensuite bathrooms. There are various other spaces to store mobility aids, and wheelchairs.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a separate dining room and lounge areas for each group of rest home and hospital residents. These are both located within a short walk for residents and staff. A number of the hospital residents were observed having meals in their bedrooms. Activities for rest home residents occur in the large lounge and sunroom. Activities for hospital residents occur in their dining room. Activities in the memory unit occur in the large open plan lounge and dining area. Residents and their visitors tend to meet in the residents' bedrooms for privacy. Furniture was observed to be appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Designated cleaning staff are on site seven days a week and are employed for a total of 91 hours per week. Interviews and review of their training records confirmed they have attended appropriate training. Bulk cleaning chemicals were stored in a designated and lockable room. A new chemical supply system enables safe decanting of cleaning products into clearly labelled containers. There is a designated laundry person on site seven days per week. The laundry person interviewed demonstrated clear understanding and adherence to laundry processes, dirty/clean flow and the safe handling of soiled linen. Residents reported satisfaction with the laundry system and said their clothes are cared for and returned in a timely manner. At the time of the audit there were no items of clothing whose owners couldn't be found. All areas within the facility were observed to be clean. The cleaning staff carry out daily and other regular cleaning routines which ensure all residents bedrooms, ablutions and communal areas are maintained in a tidy and hygienic state. The effectiveness of cleaning and laundry processes was being monitored through resident and relative feedback and the internal audit programme. There had been no reported issues with cleaning since the previous audit. Incident reports and the concerns book recorded items of missing or damaged clothing and a family member interviewed reiterated their frustration about the loss of her relative's expensive footwear. Refer to the corrective action in 1.1.13
Standard 1.4.7: Essential,	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to

Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.		staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The fire evacuation plan was most recently reviewed and approved in 2016 by the then New Zealand Fire Service. There have been no structural changes to the building which require any change to the current fire evacuation scheme. Trial fire evacuations take place six-monthly with a copy sent to Fire and Emergency Services New Zealand (FENZ). The most recent fire drill occurred on 09 February 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the maximum number of residents and staff. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region. The battery powered emergency lighting system is regularly tested. Building security is maintained by staff conducting regular door and window checks including in the memory unit which can only be accessed by a keypad locked door. Two recent security breaches by an intruder who stole items of food had been captured by the installed closed circuit television cameras and reported to the police. Access was by way of an unlocked door at night. Staff had subsequently been advised to increase vigilance and the frequency of door checks.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The MoH requested specific feedback on this standard as internal air temperatures had been identified as an area of concern. On the days of audit all of the residents' bedrooms and communal areas were adequately heated by electricity. Each bedroom had sufficiently sized external windows to allow natural light and ventilation. Heating is provided by panel heaters or plug in oil fin radiator heaters in residents' rooms which enables temperature adjustments. Communal areas are heated by central heating and there is a large gas fireplace in the rest home lounge. Areas were warm and well ventilated throughout the audit and the residents interviewed said the facility was maintained at a comfortable temperature all year round. There were no complaints or concerns about air temperatures documented and six monthly internal audits of the internal environment temperatures did not reveal overheating. Staff said although there was no air conditioning, there were plenty of portable fans available in summer and all doors and windows are opened for ventilation.

Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	There is a documented infection prevention and control programme. The programme is reviewed annually. The review includes a review of the last year's annual infection control data, plus training, infection prevention, and control audits and policies and procedures. The review is completed by the infection prevention and control coordinator. The FM is the infection control coordinator (ICC), and the position description was well defined. Exposure to infection is prevented in several ways. The organisation provides relevant training, there were adequate supplies of personal protective equipment (PPE) and hand sanitisers. Hand washing audits were completed, the required policies and procedures are documented, and staff are advised to not attend work if they are unwell. Flu and Covid-19 vaccines are offered to all staff and residents. There was a pandemic outbreak plan in place. Information and resources to support staff in managing COVID-19 were regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by the MOH were documented. There were no infection outbreaks reported since the last audit.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The FM is responsible for implementing the infection control programme and indicated there are adequate people, physical, and information resources to implement the programme. Infection control reports are discussed at management and staff meetings. The ICC has access to all relevant residents' data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory, learning, and training coordinator, and the attending GP.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are	FA	The service has documented policies and procedures in place that reflect current best practices. Policies and procedures are accessible and available for staff in all the respective wings nurses' stations, and these were current. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique, and use of disposable aprons and gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures.

practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff training on infection prevention and control are routinely provided during orientation and annual in-service education. Education is provided by a suitably qualified infection prevention and control consultant and the ICC. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance is maintained and was sighted in records reviewed. The following training was provided to staff by the service: handwashing procedure; infection prevention and control; donning and doffing of personal protective equipment and regular Covid-19 updates.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Results of the surveillance programme are shared with staff via regular staff meetings, at staff handovers, and through compiled reports. Graphs are produced that identify trends for the current year and comparisons against previous months or years. The GP is informed within the required time frames when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, respectively.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The recently nominated restraint coordinator is the clinical nurse lead who was still being provided support and oversight by the FM. Due to the clinical nurse lead being on afternoon shift the FM was interviewed about restraint minimisation. This person demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities for the restraint coordinator which is documented in a job description. On the days of audit, two residents were using restraints (bedside rails) and one resident in the memory unit had a bedside loop in place which was listed as a restraint because of their inability to consent. Two residents were using bedside loops as enablers voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. All documentation sighted, including monitoring was complete. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff

Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint coordinator and GP are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of the restraint committee meeting minutes, residents' files and interviews with the FM that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints was being monitored and analysed. Evidence of family/whānau/EPOA involvement in the decision making was documented in the files of the residents using restraints or enablers. Use of a restraint or an enabler is part of the plan of care.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint had been completed by the RN/FM and included all requirements of the standard. Resident files showed that assessments had occurred prior to restraint being used and there was documented evidence of input from the resident's family/whānau/EPOA. One family member interviewed confirmed their involvement. The general practitioner makes the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised, and the FM described how alternatives to restraints are discussed with staff and family members, for example, the use of sensor mats, low beds and placing 'landing strips'/'fall out' mattresses on the floor beside the bed. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. The restraint register contained an accurate record of the residents currently using a restraint and enabler, including the type of intervention, the date it commenced and the frequency of reviews. Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff interviewed demonstrated understanding about minimising the use of restraint and how to maintain safety when these are in use.

Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, and at six monthly restraint evaluations. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The organisation undertakes an annual review of all restraint use which includes all the requirements of this standard. Documentation of the review included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. The annual review also considered whether any changes to policies, guidelines, education or processes were indicated. Restraint activity and individual use of restraint use is reported at staff meetings. The only change in restraint activity since the previous audit has been the redesignation of an enabler to a restraint for a resident who can no longer consent to its use.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Moderate	The organisation has a clear policy and a system for complaints management which was not being adhered to. Initial review of the complaints/concerns documents was unable to be audited on day one because information was in three different files. The information on investigations and communications could not be traced as it was not filed chronologically or numbered to correlate with what was in the minor complaints book. All complaints/concerns and compliments received since 2019 were being written in the minor complaints book which allowed three entries per page. This recorded date, brief description of the complaint, action, outcome, follow up and space for a signature. Where there were notes from investigations and communications, these were either filed in another folder or stapled to a page in the minor concerns	The system for recording, acknowledging and following up formal or significant complaints and concerns was not being adhered to. Complaints documentation was incomplete. Residents and families did not feel their concerns were being taken seriously. There was insufficient evidence that complaints had been resolved to the satisfaction of the complainant.	Ensure that complaints are managed according to the Code, the organisation’s policy and best known practice. Monitor and review outcomes from actions taken to ensure that

		book which was more than half full. The 'complaints register', which the GM stated was for recording serious complaints, contained two entries; one from a past resident which was being investigated by the Office of the Health and Disability Commissioner (HDC), and the other was from a family member which had been passed on via email from the DHB. By day two of the audit, information related to 19 complaints/concerns received since 2019 was sorted, filed chronologically and cross referenced to the minor complaints book. Of these nineteen, one had been formally acknowledged in writing. The auditor considered six of these warranted a formal investigation and adherence to the Code as they related to concerns raised about suspected neglect and/or abuse of residents, cultural insensitivity, loss of valuable items, and security of the premises. There was documented and anecdotal evidence of prompt follow up, addressing and actioning each complaint or concern by the FM in all cases. Clear evidence that the complainant was satisfied or resolved about the matter was not always substantiated. There was one email from a correspondent who stated they were resolved to the fact their family's iPad was missing. They had been told in writing that the facility was not responsible for personal items as per clause D.14.4 from the ARCC "The Resident is responsible for the safety, security, and insurance cover of his or her personal belongings, but you must exercise due care and comply with relevant laws." Two family members and two residents said they were not always satisfied with the response they received when they raised concerns. The family members expressed ongoing frustration and reluctance to raise concerns, saying the actions taken did not always satisfy them or resolve the problem, and they felt their concerns were not being taken seriously. For example, they felt the FM was 'blasé' about their concerns. One family member and both residents expressed reluctance to raise concerns for fear of reprisal or		complainants are satisfied and that resolution has been achieved. 60 days

		being seen as problematic. There were also a number of compliments recorded in the minor complaints book, and positive feedback about the facility and its services was on found on the internet. Other families and residents interviewed expressed satisfaction with the care and services provided.		
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	The service provider is consistently short of at least one RN on all shifts to meet the ARCC requirements. Seventy five section 31 notifications to the DHB and MoH regarding no RN on site, have been submitted since January 2020. The roster requires at least six RNs to be employed to cover all shifts. Currently there are four RNs employed which includes the FM. Managers said that regular attempts to fill RN shortages with bureau staff from three different nursing agencies fail because the bureaus do not have enough RNs available,. The operator said they are advertising to no avail despite offering an attractive hourly wage. Evidence of online advertisements for two RNs a clinical nurse manager and HCAs was sighted along with documented recruitment efforts for the past 12 months. One applicant is being processed by immigration New Zealand. The FM stated they cannot attend to their role effectively while they are overseeing all clinical care including completing interRAI assessments, acting as the infection control coordinator, restraint coordinator, undertaking quality and risk management activities and managing all staff, including being the moderator of their Careerforce education. The HCAs and other staff interviewed were satisfied with their workloads, including the sole diversional therapist (DT). Residents and relatives said there were enough staff to attend to their needs although there were times their call bells were not responded to in a timely manner.	There are not enough RNs employed to consistently provide an RN on site 24 hours a day seven days a week. The FM repeatedly reported being under pressure to complete their workload.	Recruit and successfully employ sufficient numbers of RNs and other staff to safely meet the needs of residents and fulfil contract requirements. 60 days

Criterion 1.3.12.1 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.	PA Moderate	There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. The CD drug register sighted evidenced weekly stock takes, however six-monthly stock takes were not being consistently completed. A sample of entries sighted in the register were accurate and regular and 'as required' (PRN) controlled drugs were being signed for by two staff members. The FM reported that six-monthly stock takes could not be completed due to Covid-19 visiting restrictions and other staffing issues at the pharmacy. Follow-up documentation with the pharmacy to address the short fall was sighted.	Six monthly controlled-drug (CD) stock takes were not being consistently completed as per policy and legislation requirements.	Ensure six-monthly CD stock takes are consistently completed to comply with legislation, protocols, and guidelines. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.