# Moana House - Moana 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:

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| **Legal entity:** | Moana House |
| **Premises audited:** | Moana House |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 18 January 2022 End date: 19 January 2022 |

**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:** 47

# 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 |
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| | 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 |
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| | 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

Moana House provides rest home and hospital level care for up to 51 residents. The service is operated by Moana House Trust Board and managed by a general manager with support from a clinical manager

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 files, observations and interviews with residents, family members, management, a board member, contracted physiotherapist, staff, and a general practitioner. Residents and families spoke positively about the care provided.

The most significant change since the previous surveillance audit in 2019 is two changes in general/facility manager.

This audit identified three areas as requiring improvement. These are related to documentation of the quality system, overdue interRAI assessments and evaluations of care, and a non-conformance in medicines management. There is a rating of continuous improvement for enhancement to the external environment which benefits residents.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |

Residents and their family/whānau are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), and these are respected. The services provided support personal privacy, independence, individuality, and dignity. Staff interact with residents in a respectful manner.

The implemented systems and the environment are conducive to effective communication. There is access to interpreting services if required. Staff provide residents and family/whānau with the information they need to make informed choices and give consent.

There is a Māori health plan to guide staff to ensure that residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect, or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

A complaints register is maintained with complaints resolved promptly and effectively

## Organisational management

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

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. 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 as required. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff complies with the service's policies. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people

## Continuum of service delivery

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| 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. |

Entry processes are efficiently managed by the clinical manager, the receptionist and registered nurses. The registered nurses and the general practitioners (GPs) assess residents on admission. The care plans demonstrated appropriate interventions and are individualised. Residents are reviewed regularly and referred to specialist services and to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely stored and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

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| 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. |

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.

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

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| 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. The facility is maintaining its philosophy and practice of no physical restraint interventions. On the days of audit six residents had enablers in use at their request and with their consent.

Staff demonstrated a sound knowledge and understanding of alternatives to restraint and what to do if restraints or enablers are assessed as being needed.

## Infection prevention and control

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| 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 prevention and control programme is coordinated by a trained infection control officer, and it aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results shared with all staff. Follow-up action is taken as and when required. There has been an infection outbreak since the last audit that was managed effectively.

## 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) |
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| **Standards** | 0 | 42 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 1 | 89 | 0 | 2 | 1 | 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) |
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| **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 |
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| Standard 1.1.1: Consumer Rights During Service Delivery<br>Consumers receive services in accordance with consumer rights legislation. | FA | Moana House has developed and implemented policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The staff were observed communicating with residents in a respectful and courteous manner. Residents were encouraged to be independent, options were provided, and privacy and dignity were maintained. This was confirmed in interviews conducted with residents. The interviewed staff understood the requirements of the Code. Training on the Code is included as part of the orientation process for all staff employed and in ongoing annual training, as was verified in staff training records sampled. |
| Standard 1.1.10: Informed Consent<br>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 | The interviewed clinical manager, RNs, and healthcare assistants (HCAs) understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. General consent has been gained appropriately. Signed general consent forms were sighted in the clinical files reviewed. Resuscitation treatment plan is part of the general consent plan. Advance directives were sighted in the reviewed residents' records as applicable. Staff were observed to gain consent for daily cares. The interviewed residents and family/EPOA confirmed having signed the admission agreements and consent forms as required. Influenza and COVID -19 vaccination consent forms were sighted. Advance care plans were sighted where applicable. |

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| Standard 1.1.11: Advocacy And Support<br><br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A copy about the Nationwide Advocacy Service is given to residents and their family/whanau on admission to the service. The clinical manager reported that in the event of a complaint made or any time during service delivery, residents and their family/whānau are offered an option of an independent advocate who will be available for support as required. Brochures related to Advocacy Services were displayed and available at the reception area. The interviewed family/whānau and residents were aware of the Advocacy Service, how to access this and their right to have support persons. Interviewed staff understood the Advocacy policy and procedure. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br><br>Consumers are able to maintain links with their family/whānau and their community. | FA | The service encourages visits from residents' family/whānau and friends. A number of visitors were observed visiting residents on the days of the audit. Visiting restrictions were implemented due to COVID-19 pandemic infection prevention and control measures as per MOH guidelines. Family/whānau interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Residents are assisted to maintain links with their family and the community by having organised external entertainers visiting the facility, and residents can go out on social outings with family. Some residents had private telephones in their rooms to maintain communication with their family. |
| Standard 1.1.13: Complaints Management<br><br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints/concerns/issues 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 knew how to do so. The general manager (GM) is responsible for complaints management and follow up.<br><br>There have been no formal complaints submitted in the past two years. This was confirmed by review of the complaints register, incident accident records and minutes of residents' meetings. Communication with families, residents and staff is open and any expressed concerns are quickly acted upon to address the concern.<br><br>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints submitted to the Office of the Health and Disability Commissioner since the previous audit. |
| Standard 1.1.2: Consumer Rights | FA | The Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) posters are prominently displayed within Moana House. Residents and family/whānau interviewed reported |

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| During Service Delivery<br><br>Consumers are informed of their rights. | | being made aware of the Code and Advocacy Service as part of the admission information and explanation provided by staff on admission. The Code in English and te reo Māori was displayed on the notice board. There are pamphlets with information on the Code, advocacy services, complaints, and feedback forms at the reception area. There is a complaints and suggestion box at the reception area that is accessible to residents and family/whānau. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | All residents have individual rooms that provide visual, auditory, and personal privacy to residents. Staff were observed respecting residents' personal areas and privacy by knocking on the doors before entry. Residents and family/whānau confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Residents are allowed to bring limited personal belongings they can relate to, for example personal chair or chest of drawers. The personal belongings and property are recorded on admission and are labelled for easy identification. The residents reported that they receive back their clothes after laundering in a timely manner. Personal cares were provided behind closed doors during the audit days. The communal bathrooms had clear signage when in use.<br><br>Residents are supported to attend to community activities and to maintain their independence. The care plans included documentation related to the residents' abilities, and strategies to maximise independence.<br><br>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan. Residents stated that staff encourage and support them to maintain their independence wherever possible.<br><br>Moana House staff receive education on abuse and neglect during orientation and annually. The interviewed staff understood the service's policy on abuse and neglect, including actions to take should there be any signs. The interviewed GP, residents and family/whānau have not witnessed or suspected any abuse and neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs<br><br>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and | FA | Residents who identify as Māori are supported to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into daily practice, as is the importance of whānau. The Māori Health Plan in place is current and focussed on wellness or holistic health embodied in the Māori health model Te Whare Tapa Wha. Guidance on tikanga best practice is available. Māori cultural advisory is provided through the local DHB if required. There was a resident who is Māori but does not identify as Māori and their whānau reported that staff acknowledge and |

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| cultural, values and beliefs. | | respect the resident's individual needs. Staff have received education on cultural awareness. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs<br><br>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents' individual culture, values and beliefs were identified during the admission assessment. Residents or residents' representatives of choice or enduring power of attorney (EPOA), where appropriate, provided this information during the admission process. Interviewed residents and family/whānau confirmed that they were consulted on individual values and beliefs and staff respected these. Residents' individual preferences, required interventions and special needs were included in the care plans reviewed. |
| Standard 1.1.7: Discrimination<br><br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents, family/whānau and the GP stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. These are included in the employee handbook and are discussed with all staff during the orientation period. Ongoing staff education and open communication with family/whanau and staff are some of the strategies implemented to prevent and protect residents from discrimination. The registered nurses have completed training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| Standard 1.1.8: Good Practice<br><br>Consumers receive services of an appropriate standard. | FA | Moana House encourages and promotes good practice through evidence-based policies that are reviewed regularly, and internal audits. The service works in collaboration with external specialist services and allied health professionals, for example, wound care specialist, hospice and mental health services for older persons where required. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.<br><br>Staff receive regular education that includes mandatory training topics. This was confirmed by the interviewed staff and staff training records reviewed. The RNs have access to external education through the local hospital, though this was limited over the past year due to COVID-19 pandemic restrictions. Staff reported that they receive support from senior staff as required. |
| Standard 1.1.9: Communication<br><br>Service providers communicate | FA | Residents and family/whānau stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner of any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. The GP |

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| effectively with consumers and provide an environment conducive to effective communication. | | confirmed that meetings with family/whānau are arranged by the registered nurses (RNs) or clinical manager if requested or when required. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.<br><br>The RN stated that during the admission process residents who do not have English as their first language are offered interpreting services. Access to interpreter services is through the local district hospital board and Age Concern. Staff knew how to access interpreter services, although reported this was rarely required due to most residents able to speak English. Staff can provide interpretation as and when needed, or family/EPOA are used for those with communication difficulties. Verbal cues, translation sheets and other non-verbal prompts were used for residents who had communication difficulties. |
| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | A new general manager (GM) was appointed in October 2021. This person has extensive management experience in the New Zealand health sector working for DHBs. Responsibilities and accountabilities are described in a job description and individual employment agreement and the GM confirmed knowledge of the sector, regulatory and reporting requirements. Support for the GM is being provided by board member and managers from other aged care facilities who are members of the Community Trust Care Aotearoa (CTCA) group. CTCA is a business entity of nine aged care facilities who share common factors such as being located rurally and governed by not for profit organisations.<br><br>The clinical manager (CM) is a registered nurse (RN) with a current practising certificate who has worked as an RN at Moana House for over 10 years. This person had been acting as the CM for 12 months and as the acting GM for periods in 2021 when there was no GM. They accepted the role of CM in October 2021.<br><br>The board are kept informed verbally and in writing by the GM of all operational, quality and risk matters. This was confirmed by review of a sample of board meeting minutes and interview with the board chairperson. The board are increasing service capacity by adding another serviced apartment in the near future and planning to build and add dementia services in the mid to long term future.<br><br>The service provider has agreements with the DHB for age related residential care (ARRC) in rest home, and hospital (medical, geriatric care and palliative) respite/short stay and day services. As well as the ARCC, the service holds agreement with the DHB for provision of primary care, including palliative care, long term support-chronic health conditions (LTS-CHC) and respite services. There is also a young persons with disability (YPD) contract in place with the MoH, though there have been no YPD residents admitted for some years.<br><br>On the first day of audit there were 47 beds were occupied. Thirty residents were receiving rest |

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| | | home level care, including one person staying for respite, and 17 were receiving hospital level care. Two of these residents were admitted under the DHB post-acute care (PAC) agreement, and one was under the primary care agreement. There were no residents under the age of 65 years. Three of the residents living in the four serviced apartments were receiving rest home care. |
| Standard 1.2.2: Service Management<br><br>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 | When the GM is absent, the clinical manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a senior RN who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff said these arrangements work well. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Changes in leadership and key roles has impacted on the quality system. Although the results of internal audits, collation and analysis of incidents and infections and feedback from residents and family are reported to staff and the board, there is a requirement to develop a quality plan and amend the quality policy to reflect what is happening in practice.<br><br>Where areas for improvement are identified these are documented and actions are monitored for implementation.<br><br>A range of meeting minutes confirmed that quality data and information is reported and discussed at regular health and safety, infection control, and general staff meetings which include health and safety team meetings. Staff reported their involvement in quality and risk management activities through audit activities, training and information shared at meetings. The manager notifies all staff of corrective actions or policy/process changes by memos and verbally at meetings. Review of the most recent resident and family satisfaction surveys revealed no significant issues and high satisfaction.<br><br>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.<br><br>There is a current risk management plan which is monitored by the manager and the board. The manager is familiar with the Health and Safety at Work Act (2015) and described processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. |

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| | | There have been no injuries reported to Worksafe NZ since the previous audit. |
| Standard 1.2.4: Adverse Event Reporting<br><br>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 from 2020-2021 revealed clear descriptions of the event, that the incidents were reviewed and investigated by the CSM and signed off by the GM. Where necessary, plans to mitigate recurrence are developed and actions implemented. There was evidence that actions are monitored for effectiveness. Adverse event data including infection data is collated, analysed and reported to staff monthly.<br><br>Three Section 31 notifications for changes in general managers and board members have been submitted to the Ministry of Health and the DHB since the previous audit. There have been no other events requiring a notification. |
| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resource 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 nine staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.<br><br>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation followed by an initial performance review.<br><br>Continuing education is planned on an annual basis, including mandatory training requirements. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. All RNs and other key personnel maintain competency in first aid and CPR. Five of the 28 carers have obtained level 4 of the National Certificate in Health and Wellbeing, six have obtained level 3, six level 2 and 11 are in training to complete level 2.<br><br>Three RNs are maintaining annual competency requirements to undertake interRAI assessments. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from | FA | 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 (24/7). The service provider adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, and staff reported immediate access to advice is available when needed. Staff interviewed said there were sufficient number of staff rostered on all duties to meet the needs of residents. |

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| suitably qualified/skilled and/or experienced service providers. | | Observations and review of a four-week roster cycle and interviews with residents and their family supported this. There is an effective system to replace staff when there are unplanned absences. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage. |
| Standard 1.2.9: Consumer Information Management Systems<br><br>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents' files are paper based and all staff document in progress notes. Medical notes are completed electronically in the contracted medical services electronic system and staff print the consultation records and file this in the resident's paper file. The RNs complete care plans electronically, and copies are printed and put in the residents' paper file. These documents were sighted in the residents' clinical records sampled.<br><br>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. InterRAI assessment information is entered into the Momentum electronic database and reports are printed and stored in the residents' files. Records were legible with the name and designation of the person making the entry identifiable. Medication records are electronic in the electronic medication management system in use. Staff have individual passwords to access the electronic systems.<br><br>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' information is held for the required period before being destroyed. No personal or private resident information was on public display during the audit. The residents' files were kept in locked cupboards. Confidential bins are used for destruction of unwanted confidential information. |
| Standard 1.3.1: Entry To Services<br><br>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents' entry into the service is facilitated by the general manager (GM), clinical manager (CM), the receptionist and the RNs in a competent, timely and respectful manner. There is an admission policy and procedure to guide staff. Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. NASC assessment forms with the documented level of care were sighted in the residents' files sampled. Prospective residents and/or their family/whānau are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. A tour of the facility is conducted at that time if desired. A record of all enquiries is maintained and a follow up is conducted by the clinical manager as required.<br><br>The service's brochure and information on the facility's website have adequate and detailed information on the services provided. Family/whānau and residents interviewed expressed satisfaction with the admission process and the information that had been made available to them |

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| | | on admission. Signed admission agreements were sighted in the residents' records reviewed. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The residents' discharge or transfer is planned and coordinated by the RNs and clinical manager. An escort is provided as appropriate. The family, services van or car, community shuttle bus or ambulance services may be used to escort residents to appointments as required.<br><br>The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. The DHB transfer form is completed and required documentation attached for residents who are transferred to the DHB. Open communication between all services, the resident and the family/whanau was evidenced in the transfer records sighted. The transfer records for a resident that was transferred to acute services demonstrated that appropriate information was provided for the ongoing management of the resident. All referrals were documented in the progress notes. The resident's family reported being kept well informed during the transfer of their relative.<br><br>The clinical manager stated that if the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. The access agreement has a clause related to when a resident's placement can be terminated, and this is explained to the residents and family/ whanau on admission. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | Moana House uses an electronic medication management system that was observed on the days of the audit. The medication management policy is current and identified all aspects of medicine management in line with safe practice guidelines and current legislative requirements. Staff who administer medication had current medication administration competencies. A list of medication administration competent caregivers was maintained and was accessible to the RNs.<br><br>The RN observed administering medicines demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. Medicines were stored safely in the locked cupboards and medicine trolley in the medication room. Staff have individual passwords to access the electronic medicine records. The medicine fridge temperature and medication room temperature were monitored, and the reviewed records were within the recommended ranges.<br><br>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN completes medication reconciliation upon residents' readmission from acute services and when medication is received from the pharmacy. Clinical pharmacist input is provided on request. |

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| | | Unwanted medicines are returned to the pharmacy in a timely manner; there were no expired medicines in stock.<br><br>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. A current staff signature register was sighted. The clinical manager reported that any medication errors are documented, and appropriate investigations will be completed.<br><br>Three-monthly medication reviews were consistently completed by the GPs, as evidenced on electronic medicine charts reviewed. Dates were recorded on the commencement and discontinuation of medicines. Evaluation of pro re nata (PRN) medicines administered were completed.<br><br>There were two residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. Interviewed staff and resident demonstrated awareness of the medication self-administration process.<br><br>The organisation's warfarin management policy was not being adhered to. Nurses were receiving verbal orders for the warfarin dose and recording these on the warfarin administration record and the correct process for verbal orders was not followed. (Refer corrective action in criterion 1.3.12.1.) |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by three cooks assisted by kitchen hands and is in line with recognised nutritional guidelines for older people. The menu was last reviewed by a qualified dietitian in December 2019 and was due for review in December 2021. There was a delay in review due to COVID-19 pandemic travel restrictions. The review is scheduled on 18 February 2022. Recommendations made at the last review have been implemented. The menu was planned by a dietitian in consultation with the support services manager and the main cook. There is a summer and winter menu that rotates on a four-weekly cycle. Residents and family members confirmed satisfaction with the meals. There were no weight issues noted.<br><br>Residents' nutritional needs were identified on admission by the RNs. Special dietary requirements, including likes, dislikes and allergies were identified and accommodated in the meal plan. Records of residents' special dietary needs were kept in the kitchen. Special equipment, to meet residents' nutritional needs, was available. The meals are served in two dining rooms and residents who do not want to go to the dining rooms can have meals served in their rooms as desired. The kitchen staff coordinates special celebration with the activities staff.<br><br>The service operates with an approved and current food safety plan and registration issued by the Ministry of Primary Industries. Regular external food verification audits were completed, with the last |

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| | | one completed on 17 June 2021. Food temperatures were monitored appropriately and recorded as part of the food control plan. Fridge and freezer temperatures were monitored, and records maintained. The kitchen was clean, no expired food was found in the pantry and left-over food was covered and dated. The cooks and kitchen hands have completed a safe food safety and handling training. Food procurement is completed by the main cook through online ordering with the help of the support services manager.<br><br>Residents can provide feedback on the meals in monthly residents' meetings or as when needed. Alternate food options are provided on request. On the day of the audit residents were given enough time to eat their meals in an unhurried fashion and those who required assistance were assisted. Residents were offered extra servings and food options provided. The main cook and support services manager stated that regular kitchen staff and management meetings were held. Meeting minutes were sighted. |
| Standard 1.3.2: Declining Referral/Entry To Services<br><br>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 CM stated that if a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family/whānau are supported to find an appropriate care alternative. The prospective resident and family will be advised of the reason for the decline and will be informed of other alternative services available or referred to NASC as appropriate. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Nursing assessments were completed on admission using the organisation's assessment tools, such as, a pain scale, falls risk, pressure area risk, nutrition and continence assessments, as a means to identify any deficits and to inform care planning within 24 hours of admission. InterRAI assessments were completed within three weeks of admission, and when there was a significant change in the resident's condition (refer to 1.3.8.2). The sample of care plans reviewed had an integrated range of resident-related information. All residents had initial interRAI assessments and relevant outcome scores have supported care plan goals and interventions. Residents and families/whānau confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning<br><br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service | FA | The sampled care plans reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.<br><br>The care plans evidenced service integration with progress notes, activities assessments, medical |

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| delivery. | | and relevant allied health professionals' recommendations. Changes in care required was documented and verbally passed on to relevant staff to promote continuity of care. Residents and family/whānau confirmed participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The care plans reviewed, observations and interviews verified that care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The interviewed GP confirmed the service seeks prompt medical input, that medical orders are followed, and care provided meets the needs of residents. HCAs confirmed that care was provided as outlined in the care plans. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. Staff were observed using recommended individual resident's equipment appropriately. |
| Standard 1.3.7: Planned Activities<br><br>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by an activities coordinator (AC) with the support of two activities assistants. The AC coordinates the activities programme with the support of the support services manager. The AC is in the progress of completing diversional therapy training. Residents' activity needs are assessed as part of the admission process with input from the resident and family/whānau to ascertain residents' needs, interests, abilities, and social requirements. The AC completes the activities care plans for all residents.<br><br>The activities programme is regularly reviewed to help formulate an activities programme that is meaningful to the residents through monthly residents' meetings chaired by the AC. The residents' activity needs are evaluated when there is a significant change in participation and as part of the formal six-monthly activities care plan review.<br><br>A weekly calendar is posted on the notice boards around the facility. Daily activities are held separately for hospital level residents and rest home level residents and combined activities are held when there is external entertainment organised. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents were observed participating in a variety of activities on the days of the audit. Activities on the programme included weekly church services, puzzles, exercises, walks, music, external entertainment, movies, birthday celebrations, newspaper reading, gardening and outings. The interviewed residents confirmed that they find the programme satisfactory. A monthly activities programme is sent out to family by email and family can participate in activities on the programme if desired. This was confirmed in interviews with family. |

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| | | The day-care centre is currently on hold due to COVID-19 pandemic infection control measures. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Resident care is evaluated on each shift and reported in the progress notes by the HCAs in each shift and daily or weekly by the RNs depending on the level of care and package of care being provided. The HCAs reported that any changes noted are reported to the RNs. This was confirmed in the handover observed and in residents' records reviewed.<br><br>Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated for wounds, skin, weight loss and urinary tract infections. Residents and family/whānau interviewed confirmed being involved in evaluation of progress and any resulting changes. In two of the three eligible residents' care plans sampled, routine six-monthly evaluations were not completed as the six-monthly interRAI reassessments were not completed. (Refer to criterion 1.3.8.2). |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br><br>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 are supported to access or seek referral to other health and/or disability service providers. If there is need for other non-urgent services the GPs, clinical manager or RNs sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the mental health team, radiology, and skin specialists. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews.<br><br>Any acute/urgent referrals are attended to immediately, such as sending the resident to the public hospital in an ambulance if the circumstances dictate. Urgent referral records were sighted in the residents' files reviewed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>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 documented processes for the management of waste and infectious and hazardous substances.<br><br>Appropriate signage is displayed where necessary.<br><br>A member if the maintenance team is the designated chemical handler and has completed the required chemical handling approved handler training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff.<br><br>Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.<br><br>There is provision and availability of protective clothing and equipment, and staff were observed |

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| | | using this. |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 16 June 2022) is publicly displayed.<br><br>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. The environment was hazard free, residents were safe, and independence is promoted. External areas are safely maintained and are appropriate to the resident groups and setting. An improvement in the external environment is recognised in criterion 1.4.2.6 as an area of continuous improvement.<br><br>Residents and staff said that they are happy with the environment and confirmed they know the processes they should follow if any repairs or maintenance is required. Review of maintenance journals demonstrated that requests were appropriately actioned in a timely manner. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities<br><br>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 | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All 27 rest home/dual purpose rooms have their own toilet. Eleven hospital rooms have their own toilet and share showers between two. There are six other communal shower rooms across the rest of the facility and a bed shower is available. Communal toilets are located across all areas of the home including three visitors and staff toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available and were sighted in use to promote residents' independence. Hot water temperature monitoring is ongoing. Records showed that the temperate of water delivered to taps which residents can access is below 45 degrees Celsius. |
| Standard 1.4.4: Personal Space/Bed Areas<br><br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.<br><br>There is sufficient space on site to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. |

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| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. There are three dining areas and three lounge areas which are easily access for residents and staff. Additional to this are five smaller lounges for residents to use for visits or privacy, if required. Furniture is appropriate to the setting and residents' needs. |
| Standard 1.4.6: Cleaning And Laundry Services<br><br>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is undertaken on site in a fit for purpose laundry by staff employed to carry out laundry tasks each day of the week. Staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.<br><br>Designated cleaners are on site for up to six hours each every day. They attend regular training in subjects appropriate to their roles, as confirmed in interview and sighted in rosters and training records. Chemicals were stored in lockable cupboards and were in appropriately labelled containers. All areas inspected throughout the facility were spotlessly clean. The methods for cleaning are reviewed and new systems are introduced if required. Residents and their families commented that the home was always clean and odourless. Cleaning and laundry processes are monitored for effectiveness through the internal audit programme. These audits have revealed no issues. |
| Standard 1.4.7: Essential, Emergency, And Security Systems<br><br>Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to 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 current fire evacuation plan was approved by the New Zealand Fire Service on the 25 March 1988. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in September 2021. The residents in the serviced apartments are always included in fire drills. These apartments are within and linked to the main facility's emergency systems and sprinklers and hard wired smoke detectors are installed.<br><br>The new staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.<br><br>Moana House is a designated Civil Defence point for community assembly in the event of disaster or civil defence emergency. The facility is mindful of this and stores include food, blankets, mobile phones and portable gas which can provide for a maximum of 51 residents and staff and community |

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| | | for up to five days. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region. The system was discussed with the support services manager, who is a member of the local emergency response team. The site uses town supply water and has its own bore for emergency use. There is a generator on site. Emergency lighting is regularly tested and often used because of frequent power outages.<br><br>Call bells alert staff to residents requiring assistance. Residents and families reported staff usually respond promptly to call bells.<br><br>Doors and windows are locked each evening at a predetermined time to maintain security. There have been no security incidents since the previous audit. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br><br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by central electric heating systems with outlets in residents' rooms and in the common areas. All parts of the home were well ventilated throughout the audit and residents and families confirmed the environment is maintained at a comfortable temperature. |
| Standard 3.1: Infection control management<br><br>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 | Moana House has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external specialists. The infection control programme is reviewed annually and was last reviewed in November 2021.<br><br>The clinical manager is the designated infection control coordinator (ICC), whose role and responsibilities are defined in their job description. The ICC has delegated some responsibilities for infection prevention and control to one RN. Infection control matters, including surveillance results, are reported monthly to all staff, and tabled at the management and staff meetings. The IPC committee includes the clinical manager, an RN, a health and safety officer and a staff representative.<br><br>There is signage at the main entrance to the facility requesting anyone who is or has been unwell with flu like symptoms in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The interviewed staff understood these responsibilities. All visitors undergo the COVID-19 symptoms screening and contact tracing information collected at each visit. All visitors wear face masks during the time of the visit. Covid-19 QR code was available at the entrance to the facility. |

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| Standard 3.2: Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has been in this role for more than a year and has appropriate skills and knowledge for the role. They have attended relevant infection prevention and control education, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GPs and public health unit, as required. The ICC has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.<br><br>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. There was an infection control room set up with extra personal protective equipment set aside for use in case of an emergency and any outbreak. Adequate resources were sighted in the infection control room and the daily use supplies. Updated information on COVID-19, including vaccination information was available and easily accessible to staff and residents. All eligible residents have received the COVID-19 vaccine. There are processes in place to cohort staff and residents if there is an outbreak within the facility. |
| Standard 3.3: Policies and procedures<br><br>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 practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed in January 2021 and included appropriate referencing.<br><br>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. Hand washing and sanitisers were readily available around the facility. The interviewed staff demonstrated knowledge of infection control policies and practices. |
| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance was maintained, and high staff attendance levels were demonstrated. There was evidence that additional staff education has been provided in response to the COVID-19 pandemic.<br><br>Education with residents is on a one-to-one basis for any infections and in groups during residents' |

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| | | meetings and this included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather and COVID -19 pandemic infection control measures. This was verified in residents' meeting minutes and short-term care plans sighted. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, multi-resistant organisms, skin, ear nose and throat, the upper and lower respiratory tract. Infection reports are completed for all infections and the ICC reviews all reported infections. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. This was confirmed in the handover observed and in staff interviews.<br><br>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Hand hygiene audits were completed for all staff, and corrective actions were implemented as required. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends for the current month are compared with the previous month.<br><br>There has been an infection outbreak since the last audit. Infection prevention and measures implemented were adequate to contain the outbreak. Appropriate documentation and notification requirements were completed. |
| Standard 2.1.1: Restraint minimisation<br><br>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 if required. The service has a philosophy and practice of no restraint which has been maintained for many years.<br><br>At the time of this audit, six residents had bed levers in place to assist with positioning themselves in bed. Each of these had been consented to by the resident and the ongoing need for these was being reviewed every six months. Alternatives to the use of restraint include the use of low beds, sensor mats, physiotherapy interventions, effective distraction and redirection, and provision of an engaging activities programme. This was evident by observations on the audit days, residents' files reviewed, and from interviews with staff from a range of roles.<br><br>One RN is designated as the restraint coordinator with the clinical manager providing support and oversight for enacting the policy and providing staff with ongoing restraint education. The CM demonstrated a sound understanding of the organisation's policies, procedures and practice and the responsibilities of the role. |

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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) |
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| Criterion 1.2.3.1<br>The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | Changes in management have led to changes in policy documentation. The new GM is developing methods for measuring clinical outcomes. This will likely include a balanced scorecard approach with baseline scales and performance indicators. Until the revised systems are implemented the quality policy provides a scant overview and the annual quality plan has not been developed. Moana House has not been benchmarking its quality indicators with the other eight CTCA facilities, but all other quality activities, such as internal audits, event data analysis and reporting and resident feedback has been maintained. | The new quality policy lacks sufficient detail in describing the current quality system and there is no quality plan as required in the ARCC agreement. | Ensure policy and procedures match current practices in quality management. Develop a quality plan.<br><br>90 days |
| Criterion 1.3.12.1<br>A medicines management | PA Low | The service is using the electronic medication management system except for warfarin prescription. The organisation’s policy requires the warfarin prescription to be completed by the GP on the INR/Warfarin record sheet and faxed back to | The RNs are receiving verbal orders and | Ensure all prescribed medicine are |

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| 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. | | the facility. In contrary to the policy, verbal orders were being received from the practice nurse at the medical centre and the dose written on the warfarin administration record by an RN. Another staff member who has medication administration competency verifies the dose with the practice nurse over the phone. The policy for verbal orders states that the prescribing GP is to amend the medication chart within two working days, and this was not being adhered to. The risk rating is low as the process was remedied on day two of the audit. All warfarin prescriptions were recorded in medi-map by the GP. The clinical manager stated that this is going to be the ongoing process. The warfarin management policy and protocol is going to be reviewed and amended. | transcribing warfarin dose onto the warfarin administration form which does not adhere to the organisation's warfarin management policy or best known safe practice in medicine management. | recorded by an authorised prescriber and warfarin management policy is adhered to.<br><br>30 days |
| Criterion 1.3.8.2<br><br>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Care plan evaluations were completed as residents' needs change. Where progress was different from expected, changes were made to the plan of care. Some of the routine six-monthly care plan evaluations were not completed in two of the residents' files sampled for review. However, in interviews, the GP, HCAs, RNs and the residents' families confirmed that the residents were receiving appropriate and adequate care to meet their needs. The residents' progress notes evidenced regular evaluation of care provided and regular reviews by the GPs. There are three interRAI trained RNs. The clinical manager reported that there is a backlog of interRAI reassessments and routine care plan evaluations due to staff resignations and some interRAI trained RNs having to cover the daily nursing duties and did not have adequate time to do the due interRAI reassessments. A new RN was employed and will be commencing work in the following week. Two booked interRAI training courses were cancelled last year due to the COVID-19 pandemic. There is a plan in place to have more staff trained as there are new RNs employed. | 17 six-monthly interRAI reassessment due six-monthly review were overdue with an interval of between three 37 days to 123 days. Routine six-monthly care plan evaluation for two residents' files reviewed were not completed. | Ensure all routine interRAI reassessments and care plan evaluations occur six-monthly as per ARRC contract requirements.<br><br>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.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| Criterion 1.4.2.6<br>Consumers are provided with safe and accessible external areas that meet their needs. | CI | The physical environment provides safe mobility and promotes independent movement for older people. The provider has converted a previously uninviting internal courtyard into an accessible and safe sensory garden. This area is a popular place for residents and their families to meet, relax, wander and engage with nature. Residents were consulted on the design, voted on seating choices and assisted with fund raising. Residents have donated garden ornaments from their homes which connects them to the place. Evaluation of the completed project included gaining feedback from residents. All were positive ‘I can go out there when I want and I feel safe’; ‘I love the flowers, there is a rose which is a cutting from my husband’s rose plant’; ‘I love to hear the water running and smell the lavender’.<br>Staff and families said the new garden provided much joy to residents and was helpful in distracting upset or agitated residents. | Residents’ well-being is improved by being able to access a safe, peaceful garden area which stimulates their senses, and participate in gardening and harvesting. Agitated or upset residents have been readily distracted and soothed by walks in the garden. |

End of the report.