

Chetty's Investment Limited - Alexander Lodge Rest Home

Introduction

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

The audit has been conducted by 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:	Chetty's Investment Limited	
Premises audited:	Alexander Lodge Rest Home	
Services audited:	Rest home care (excluding dementia care); Residential disability services - Psychiatric	
Dates of audit:	Start date: 28 January 2022	End date: 28 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:	22	

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

Chetty's Investment Limited - Alexander Lodge Rest Home provides care for up to 23 residents requiring rest home level care and residential disability care - psychiatric.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included a review of policies, procedures, residents' and staff files, observations and interviews with residents, family members, the management team and owner, and staff.

There were no areas identified as requiring improvement at the last audit. There are two areas requiring improvement at this audit. These relate to neurological monitoring post unwitnessed falls and timeliness of interRAI assessments.

Residents and family members interviewed were satisfied with the managers, staff, and the services provided.

Consumer rights

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

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Resident's and family members are informed of the complaints process of admission. There have been no complaints reported and residents and family members interviewed confirm they are aware of the complaints process and have no complaints.

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.
---	--	--

The organisation's philosophy, mission and vision statement are documented. The quality and risk plan documents the goals and objectives. The manager (who has been the rest home owner since 2013), and the registered nurse/clinical manager work together to ensure services offered meet residents' needs, legislative requirements and good practice standards. Both are on call when not on site.

The quality and risk system and processes support effective, timely service delivery. The quality management system includes an internal audit programme, complaints management, compliments, incident/accident reporting, hazard management, resident satisfaction surveys, and restraint/enabler and infection control data collection. Quality and risk management activities and results are shared among managers, staff, residents and families, as appropriate. Corrective action planning is well documented.

New staff have an orientation. Staff participate in relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that all their needs and wants are met.

The service has a documented rationale for staffing which is implemented.

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.
--	--	--

Residents are assessed before entry to the service to confirm their level of care. The clinical manager (CM) is responsible for the assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs. Interventions are appropriate and evaluated by the CM as per policy requirements.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activity plans are completed in consultation with family/whānau, residents, and staff. Residents and family/whānau expressed satisfaction with the activities programme in place.

There is a medicine management system in place. The organisation uses a paper-based system in prescribing, dispensing, and administration of medications. The general practitioner (GP) is responsible for all medication reviews. Staff involved in medication administration are assessed as competent to do so.

The food service caters for residents' specific dietary likes and dislikes. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours.

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.
--	--	--

The building has a current building warrant of fitness and an approved fire evacuation plan. There have been no significant changes to the facility since the previous audit except for some renovation and refurbishment.

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 service has a commitment to not using restraint. The restraint minimisation and safe practice policy and definitions complied with the standard. There were no restraints or enablers in use during the audit

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
---	--	--

The infection control surveillance 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	14	0	0	2	0	0
Criteria	0	37	0	0	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and there is a compliments/concerns and complaints form readily available at the main entrance. There have been no complaints received since the last audit. A complaints register is available.</p> <p>The manager and RN who is also the clinical manager (CM) are jointly responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The manager and CM advised there have not been any complaints received from the district health board (DHB), Ministry of Health, or via the Health and Disability Commissioner since the last audit.</p> <p>Residents and family members interviewed confirmed they are aware of the complaints process and have no complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	<p>FA</p>	<p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. The incident forms sampled demonstrated that all incidents are reported to family/whanau.</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Residents and family members interviewed confirmed they were well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents or concerns and were very satisfied with the communication provided by staff.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required. No interpreters were required for current residents. Staff report they understand body language prompts from residents that are 'non-verbal', or use communication cards.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The quality and risk plan has current goals which are being monitored for progress by the manager (who is also the owner and director since 2013) and by the clinical manager. The manager owns two aged related residential care (ARRC) facilities in Auckland, purchasing the second care home approximately four years ago. Both care homes provide rest home level care only and are of a similar size. The manager advises he visits both care homes daily including weekends. The manager is responsible for ensuring the day-to-day care needs of the residents at Alexander Lodge Rest Home are being met.</p> <p>The CM has extensive clinical experience in aged care and has worked in this care home since prior to the current owner's purchase. The CM works at least three days a week on site, a minimum of 20 hours – usually more, and is on call when not on site. Staff verified appropriate clinical advice and support is available at all times. The CM provides some education for staff at the managers other care home, working approximately four hours per week at that site. The clinical manager has evidence of current interRAI competency and ongoing education related to the role. The manager and the CM are attending education related to operating and managing age care facilities as confirmed by interview and records of attendance.</p> <p>Since the last audit there have been no changes to the management team or services provided at Alexander Lodge Rest Home. Ongoing refurbishment of the facilities is occurring in a scheduled manner. The second RN employed at the last audit resigned in March 2021. The CM is covering all RN responsibilities while recruitment continues for another part time nurse.</p> <p>Interview with the owner/manager confirmed the service holds agreements with the DHB for rest home level care under the Age Related Residential Care Contract (ARRC), Respite Services, Long Term Support Chronic Health Conditions (LTS-CHC) and the Ministry of Health, Disability Support Services Outcome agreement for younger people with disabilities.</p> <p>Twenty two of the 23 available beds were occupied on the first day of the audit. Seventeen residents were receiving rest home level care under the ARCC contract. Four residents were under the age of 65 years and included residents receiving mental health services, and one resident is assessed as having long term chronic health conditions. There is one tenant living onsite who resides in a downstairs apartment. This person does not receive any services from the care facility.</p> <p>The quality, risk and business plans have current goals which are being monitored for progress by the manager</p>

		and the CM. Regular reports on service delivery and organisational performance are shared with all staff at their regular monthly meetings.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Alexander Lodge Rest Home has a quality and risk management system which is understood and implemented by service providers. This is linked to the objectives and quality improvement plan and goals/objectives. The quality and risk programme includes compliments and complaints management, internal audits, satisfaction surveys, incident and accident reporting, hazard management, health and safety, restraint minimisation, infection control data collection and management. Regular internal audits are conducted, which cover relevant aspects of service including aspects of care including medication management, documentation, food services and the facility/equipment. Compliments received are documented and communicated to staff.</p> <p>Policies and procedures are readily available for staff in a paper-based manual. These have been developed by an external consultant and then reviewed and localised as required to reflect the needs of Alexander Lodge Rest Home. The clinical manager reviews the existing policy manuals annually and notes any changes required. Amended or new policies are communicated to staff at staff meetings. The clinical manager is responsible for document control processes. Policies and procedures are discussed where applicable during orientation and the staff education programme.</p> <p>A resident satisfaction survey occurred in 2021. Six residents and/or family members provided feedback on the services and were very satisfied.</p> <p>If an issue or deficit is found, a corrective action is put in place to address the situation. Quality information is shared with all staff via shift handover as well as via the monthly staff meetings. The minutes of staff meetings are made available to staff. All staff interviewed confirmed they were kept informed of relevant quality and risk information including new or amended policies and procedures.</p> <p>Actual and potential hazards/risks are identified in the hazard register. The hazard register and mitigation strategies have been recently reviewed. Organisation risks are documented and reviewed at least annually or sooner where indicated. The manager and clinical manager discussed the issues related to the Covid-19 pandemic and the processes for ensuring they keep current with the frequent sector changes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and</p>	PA Moderate	<p>There is an adverse event reporting form. Events are reported and investigated, and actions taken in response. Neurological observations are not consistently occurring for residents following unwitnessed falls and this is an area requiring improvement.</p> <p>Adverse event data is collated, analysed and discussed at monthly staff meetings.</p> <p>The owner understands the requirements for essential notification reporting. They advised there have been no</p>

<p>reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>section 31 notifications of significant events made to the Ministry of Health, or other regulatory body since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks and validation of qualifications and practising certificates (APCs), where required. Most of the staff have worked in the care home since prior to the manager purchasing the facility. The newest staff member is personally known to the management team. As such, police vetting was not deemed to be required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>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 and a performance review after a three-month period, and annually thereafter.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. In response to the national Covid-19 alert levels in 2021, the clinical manager has been undertaking one on one education sessions with staff. The two caregivers interviewed advised they have completed a level two industry approved qualification. In addition, there is a process of undertaking regular case reviews of residents that are new to the care home or have changing needs. The responsibilities of information gathering are shared by the caregiving team and the clinical manager, and the results are included in the ongoing staff education programme.</p> <p>The clinical manager is maintaining annual competency to undertake interRAI assessments. Records reviewed verified the date of their required training and completion of ongoing competency (January 2022).</p> <p>Applicable staff have current medicine competency.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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 main caregivers shift is a 12-hour shift morning and night, with additional caregiver hours rostered to cover peak care requirements. Care staff are responsible for undertaking cleaning and laundry duties throughout the day and evening. Four hours are allocated weekdays for activities. The manager is responsible for maintenance activities and assists with meal preparation, and care giving when required.</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed from both the manager and the clinical manager as required. Care staff interviewed confirmed there were adequate staff available to complete</p>

		<p>the work allocated to them. Residents and family interviewed supported this. Observations and review of the last three-week roster cycle confirmed adequate staff cover has been provided. Staff confirmed replacement staff are obtained for all unplanned staff absence.</p> <p>The staff first aid certificates were due for renewal at the end of 2021. Due to Covid alert levels in place staff have not been able to complete this training. The manager has been liaising with an approved first aid provider to have an onsite training day scheduled and is awaiting confirmation of a date. In the interim, the clinical manager has discussed with staff an overview/response to key clinical emergency events as part of the November 2021 staff meetings, as per the meeting minutes sampled and staff interview. The clinical manager is on call when not on site.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There is a documented policy on the management of the medication system. All medication files sampled confirmed that they were reviewed as required and discontinued medications were signed and dated by the GP. Allergies were documented, identification photos present and three-monthly reviews were completed. Medication charts were legibly written. The caregiver was observed administering medication correctly.</p> <p>Medication reconciliation is conducted by the CM when a resident is transferred back to the service. The service uses pharmacy pre-packed packs that are checked by the CM on delivery. Monitoring of medicine fridge and room temperatures is conducted regularly and deviations from normal were reported and attended to promptly.</p> <p>The controlled drug register was current and correct. Weekly, monthly and six-monthly stock takes were conducted, and all medications were stored appropriately. All expired medications were returned to the pharmacy in a timely manner.</p> <p>There were no residents self-administering medicines at the time of the audit. Self-administration medication policy and the procedure is in place if/when required.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records of this were sighted. The medicines management system complies with legislation, protocols, and guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met</p>	FA	<p>The service employs a cook in the kitchen and is assisted by an experienced caregiver and facility manager (who is also the owner-director) when absent. There is an approved food plan for the service which expires on 20 June 2022. The menu was reviewed by a dietitian within the past two years. The menu appraisal evaluated the three weekly summer and winter cycle menus in consideration of the nutritional and required menu planning practices appropriate for older adults. 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.</p>

<p>where this service is a component of service delivery.</p>		<p>The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. The residents' weights were monitored regularly, and supplements were provided to residents with identified weight loss issues. Nutritional snacks are available for all residents 24 hours a day if required.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges, and freezers are maintained. Thermometer calibrations were completed every three months. The cook demonstrated a good understanding of the required reheating and chilling process. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. 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.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents have their level of care identified through the needs assessment carried out by the NASC agency. All residents' assessments covered the physical, psycho-social, spiritual, and cultural aspects of each resident. Admission and interRAI assessments are completed utilising information gained from either the resident, the nominated family representative, referring agency and/or the previous provider of health, other health team members, observations and examinations carried out by the nursing team.</p> <p>Assessments and care plans sampled were detailed and care staff reported that interventions developed were easy to follow. All outcomes from interRAI assessments and other additional assessments were identified and addressed in the care plans sampled.</p> <p>In interviews conducted, family/whānau and residents expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Activities are appropriate to the needs, age, and culture of the residents. The activities coordinator develops an activity planner and daily/weekly activities are posted on the notice boards. Residents' files have a documented activity plan that reflects the resident's preferred activities of choice. Throughout the audit, residents were observed being actively involved with a variety of activities. Activity plans are reviewed at least six monthly or when there is any significant change in participation, and this is done in consultation with the CM. The activities vary from scrabble, bingo, paper reading, trivia questions, hopscotch, music, movies, indoor fitness - Zumba, exercises/walking, and church services every weekend. The activities coordinator reported that they have group activities and engage in one-on-one activities with some residents. Activities are modified according to abilities and cognitive function.</p> <p>The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents and family members interviewed reported overall satisfaction with the level and variety of activities provided.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented on each shift by care staff in the progress notes. All noted changes by the caregivers are reported to the CM in a timely manner.</p> <p>Each resident's care plan and interRAI assessment is evaluated, reviewed, and amended either when clinically indicated by a change in the resident's condition or at least every six months whichever is earlier. The evaluation reflected the achievement of the set goals over the previous six months. The evaluations are carried out by the CM in conjunction with the care staff, family/whanau, residents, GP, and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan.</p> <p>Short-term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process.</p> <p>Interviews verified residents and family/whānau are included and informed of all changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (BWOFF) which expires on 09 February 2022 was publicly displayed. The manager is responsible for ensuring the ongoing checks to maintain the BWOFF is occurring. There have been no structural changes to the building since the previous audit. Some repainting and refurbishment of residents' rooms, bathrooms and communal areas was occurring.</p> <p>There has been no changes to the approved fire evacuation scheme for the building (EVACP 05824-12) dated 26 April 2012. The most recent fire drill occurred on the 10 December 2021 and records sighted.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance programme is defined and appropriate to the size and scope of the service. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed by the CM to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and management meetings. Evidence of completed infection control audits were sighted.</p> <p>Staff interviewed confirmed that they were informed of infections as they occur. The CM reported that the GP is informed on time when a resident has an infection and appropriate antibiotics were prescribed for all diagnosed infections.</p>
<p>Standard 2.1.1: Restraint</p>	FA	<p>Alexander Lodge Rest Home is maintaining its philosophy and practice of being a restraint free environment but has policies in the event that a restraint may be required. The restraint minimisation and safe practice policy</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>contains definitions and information that is congruent with the requirements of this standard. It states that the only approved restraints would be lap belts and bed sides. Policy includes processes for assessment, approval and consent, monitoring and review, evaluation and staff training.</p> <p>There were no restraints or enablers in use during this audit. The regular staff meeting includes discussions on restraint minimisation and confirmed that there has not been any restraints or enablers used in the preceding month. Care staff interviewed confirmed restraints and enablers have not been used for a 'long time'.</p>
--	--	---

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA</p> <p>Moderate</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident records from 2021 and 2022 reviewed showed that these were reported and followed up in a timely manner. A review of five unwitnessed fall reports demonstrates there is inconsistency in both the frequency and duration of neurological observations and at times neurological observations are not occurring. There are two post neurological monitoring forms available, and the monitoring timeframes specified are different on each form. The organisation’s policy does not provide clear guidance for staff on what is required.</p> <p>One resident was admitted to the DHB for inpatient services following another reported incident/event. Appropriate clinical care was sought for the resident at the time.</p>	<p>The head injury management policy (December 2017) and the two versions of the neurological monitoring forms in use provides inconsistent information for staff on the neurological monitoring that is to occur post unwitnessed falls. Neurological monitoring of residents post unwitnessed falls is not consistently occurring. When monitoring is occurring, there is variation in the frequency and duration.</p>	<p>Update the head injury management policy and associated monitoring form to provide clear guidance for staff on the required neurological monitoring of residents post unwitnessed falls, and ensure these requirements are consistently implemented for applicable falls.</p> <p>90 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>All files sampled identified that initial assessments and initial care plans were resident centred, and these were completed within the required time frames. InterRAI assessments were completed within 21 days and based on this assessment and the staff's observation of the resident, long-term care plans were also developed.</p> <p>The interRAI report generated from the interRAI database demonstrated that reviews were not completed within the required timeframes for four (4) residents. The CM reported that these were being prioritised and the process of updating the overdue assessments had already commenced. All the other five (5) residents' files reviewed demonstrated that the ongoing six-monthly evaluation process was completed as per policy requirements and these assessments reflected the resident's current status. Residents, family and care staff interviewed reported being involved in the care planning process.</p>	<p>Four (4) interRAI re-assessments that were generated from the interRAI database were not completed promptly with overdue time frames ranging from 2-18 days.</p>	<p>Ensure all interRAI assessments are completed within timeframes that safely meet the needs of the residents and ARCC contract requirements.</p> <p>90 days</p>
--	------------------------	---	---	---

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.