

Terrace View Lifecare Limited - Terrace View Retirement Village

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:	Terrace View Lifecare Limited	
Premises audited:	Terrace View Retirement Village	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 10 February 2022	End date: 10 February 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:	38	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

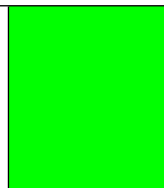
Terrace View Retirement Village provides rest home and hospital level care for up to 64 residents. The service is operated by two directors, one of whom is the owner, and is managed by a facility/village manager and a clinical nurse manager. There has been significant staff turnover, especially of senior staff since the last audit, which has caused additional challenges for the management team. Residents and a family member interviewed are fully satisfied with the care and support being provided.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff and a nurse liaison from the local general practice.

Two areas requiring improvement were identified in the audit. One relates to staff education records, an issue also identified in the previous audit, and the annual appraisal process. The other is in regard to corrective action processes. Improvements have been made to the use of an acuity tool to more accurately ensure safe staffing levels, which was an issue raised for corrective action at the previous audit.

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.



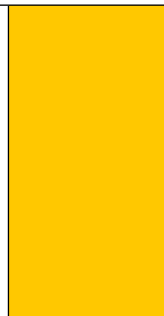
Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services; however, this has not been required.

A complaints register is maintained with complaints resolved promptly and effectively.

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 strategic business plan includes the scope, vision, mission statement and objectives of the organisation. A documented quality and risk management plan describes the quality and risk systems and guide their implementation. Monitoring of the services is provided to the governing body in comprehensive monthly reports and meetings. 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 and internal audits are documented. 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 are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery. Staffing levels and skill mix meet the changing needs of residents.

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.		Standards applicable to this service fully attained.
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The service is delivered in a manner that provides continuity and promotes a team approach for the care of the residents. There are policies and procedures in place, which support assessment, planning, provision of care, evaluation, and transfers for residents. These safely meet their needs and the facility's contractual obligations. The multidisciplinary team includes a facility manager, clinical nurse manager, registered nurses, and several General Practices who assess the needs of the resident on admission. Care plans are individualised, and resident focused with interRAI assessments completed. Files reviewed demonstrated the care provided and the needs of the residents are reviewed and evaluated in a timely manner.

The service provides a planned activity programme which has a variety of individual and group activities and maintains links with the community as the COVID-19, traffic light system allows.

The medication policy is based on current best practice for medication management and the staff who administer the medications are competent in medication management.

The onsite kitchen meets the nutritional needs of the residents and there is food available 24 hours of the day. Residents with specific dietary requirements and likes and dislikes are well catered for. The service has a four-week rotating summer and winter menu which has been approved by a registered dietitian.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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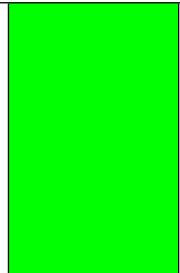
The facility has a current building warrant of fitness and there have been no alterations to the building since the last audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has policies and procedures that support the minimisation of restraint. No enablers or restraints were in use at the time of audit. A recent use of an enabler had been voluntary and according to the resident's preference. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme is led by an experienced and trained infection control nurse and aims to prevent and manage infections. The infection control policy identifies current best practice for infection control management. Aged care specific infection surveillance is undertaken, with data collated monthly and presented at the quality meeting, registered nurse meeting and general staff meeting. Staff demonstrated good principals and practice around infection control, which is guided by relevant policies and supported with regular education.

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	1	1	0	0
Criteria	0	37	0	1	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)
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>	FA	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Copies of the complaints form are at the front reception desk near a publicly accessible suggestions/complaints box.</p> <p>Complaints are entered into an electronic complaints register. Those reviewed included an overview of the issue, the actions taken, adjustments made until an agreed resolution and confirmation that follow-up and closure had occurred within the timeframes of the Code. Action plans showed any required follow up and improvements have been made. The village manager is responsible for the management and follow-up of concerns and complaints. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required to assist a person who wants to make a complaint.</p> <p>One complaint received from the Health and Disability Commissioner's office prior to the last audit has since been closed. Documentation to confirm this was sighted and a description of the corrective actions implemented was provided by the manager. Evidence to confirm their implementation was viewed in the records reviewed.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>Residents and a family member stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Details about how to access interpreter services and support for people with communication disabilities are detailed in an interpreter policy and procedure. Staff interviewed were aware of where to get this information from but confirmed the clinical nurse manager's report that this has not been required. All residents can speak English; however, one person for whom English is their second language often slips into their native language. Staff reported they just ask the person to speak in English and they are happy to comply. Staff are aware of the need to ensure people who require spectacles or hearing assistance devices have these needs met.</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 strategic business plan is reviewed annually and the 2021 – 2023 version was viewed. This included the purpose, values, scope, direction and goals of the organisation and stated how the service provider takes a holistic approach and is constantly striving to excel and provide the best aged care services in the district of Ashburton/mid-Canterbury. Documents provided describe annual and longer term objectives and associated operational plans. An example of a monthly report (for December 2021) was viewed and is reportedly an example of the monthly reports provided to the two directors who are the governance unit for this aged care service/village. The report showed adequate information to monitor performance is reported including emerging risks and issues of potential concern. The owner/director also visits at least monthly, or more depending on the time of year or if there are any specific concerns.</p> <p>The service is managed by a village manager, who is also the Terrace View aged care facility manager. With a business management degree and over 30 years in the health sector, this person holds relevant qualifications and experience. They have been in this role for six years after having three years managing another aged care facility. Responsibilities and accountabilities are defined in a job description and an individual employment agreement. The village manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at in-house and locally based training sessions, participating in District Health Board meetings (via Zoom) every two months, attending Aged Care Association training days and conferences, attending the quality consultant's training opportunities and undertaking on-line training opportunities.</p> <p>In addition to providing care for some private paying residents, the service holds contracts with the Canterbury District Health Board to provide rest home and hospital level care (Aged Related Residential Care Agreement) as well as respite and palliative care. At the time of audit 60 of the total 64 registered beds were occupied. There are five people in the apartments who receive rest home care packages. Two private paying residents in the apartments have just been assessed as requiring hospital level care and are due to transfer into a hospital bed in the main part of the care facility. Their care is currently being provided by the Terrace Village hospital staff. The apartments are in wings immediately off the care facility areas. A total of twenty six residents were receiving rest home services and</p>

		<p>12 hospital level care at the time of audit.</p> <p>The village manager was not available on the day of this unannounced surveillance and although the clinical nurse manager has only been in their role and at the facility for five months, they did their utmost to meet the requests of the auditors. Gaps in information at the end of the day were filled via a telephone conversation between the village manager and the lead auditor the following day and additional documents for evidence were provided via email.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. Its implementation is overseen by a quality consultant who provides support and advice when required. The quality and risk system includes the management of incidents and complaints, audit activities, a regular patient/family satisfaction survey, monitoring of outcomes, clinical incidents including infections and risk and hazard reviews.</p> <p>Staff reports and two months of meeting minutes reviewed confirmed review and analysis of quality indicators have occurred and that related information is reported and discussed at the monthly staff meetings. Staff reported their involvement in quality and risk management activities through taking on responsibilities for infection prevention and control, review of residents' records, attending education and reporting hazards. Internal audits are primarily undertaken by the village manager and although there was a gap in the completion of these during 2021, there was evidence that a concerted effort had been made to bring these up to date in 2022.</p> <p>A corrective actions log showed these were once consistently implemented to address any shortfalls in the quality and risk management system; however, this has not been occurring in a formal manner over the past year and has been raised for corrective action.</p> <p>Resident and family satisfaction surveys are completed annually and a copy of the 2020 one was provided. The 2021 one was not completed due to other demands on managers' time; however, meeting minutes of weekly to monthly residents' meetings demonstrated the residents' concerns have been heard, actioned and reviewed, including at the individual level. Such concerns primarily covered food, concerns regarding the impact of COVID-19, aspects of the environment and laundry. The village manager completes monthly checklists that cover a range of environmental, health and safety and quality and risk issues and a copy of the January one from December 2021 was viewed.</p> <p>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.</p> <p>The village manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Associated documents were provided including an updated risk register and a current hazard register. The manager is the health and safety officer, is familiar with the Health and Safety at Work</p>

		Act (2015) and has implemented requirements. There are comprehensive policies and procedures to support the health and safety system.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form within the electronic system, as per requirements within the policies and procedures. A sample of incident form entries reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is categorised electronically and benchmarked against similar organisations throughout the country. The clinical nurse manager writes a monthly report following the collation and analysis of adverse event data. This sits alongside an infection control report and is provided to the village manager and ultimately the directors.</p> <p>The clinical nurse manager described essential notification reporting requirements, which both the facility and clinical nurse managers work together on. They advised that over the past 12 months there have been several notifications regarding insufficient registered nurse cover and how the service provider has managed these. The clinical nurse manager was not aware of any other notifications, police investigations or coroner's inquests over the past year.</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>	PA Moderate	<p>Human resources 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. Practising certificates (APCs) are checked for all employed and contracted health professionals providing services to residents. 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, although the managers were reminded of the need to ensure all completion sections are consistently signed and dated as per the policy. For more recent employees, a performance review with the clinical nurse manager is completed after a three-month period.</p> <p>Continuing education is planned on both a/an biannual/annual basis, including topics to meet mandatory training requirements. A mix of on-line courses, internal and external presentations and self-learning packages are used. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments with two registered nurses and the clinical nurse manager having completed them and one other registered nurse</p>

		<p>currently doing them.</p> <p>Records on staff training attendance could not verify training requirements are being consistently met and the previously raised corrective action remains open, with the addition of the need for all staff to have a current annual performance appraisal.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There are documented and implemented processes for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). These include an annual leave and rostering guidelines document and one on staffing rationale. An acuity tool has been used to assess the needs of all residents within the past three months and the results confirmed staffing levels are currently safe. Registered nurses or the clinical nurse manager may adjust staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>The clinical nurse manager has implemented a system whereby senior level four caregivers are working under the supervision of registered nurses to undertake specific duties when a second registered nurse is not on duty. Designated tasks may be weighing residents, doing simple wound care and medication administration. This system is working well and has taken some pressure off the registered nurse team.</p> <p>Care staff and registered nurses reported there were adequate staff available to complete the work allocated to them with only an occasional day when a roster needs modifying to meet residents' needs. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence, or a staff person may extend their shift. All except one new registered nurse has a first aid certificate, which ensures there is at least one staff member on duty who has a current first aid certificate, as there is 24 hour/seven days a week (24/7) registered nurse (RN) coverage for hospital care residents. A senior caregiver who has a current first aid certificate takes on this role when the 'exception' is on duty, although this RN is booked for an upcoming course. The clinical nurse manager has stepped into a registered nurse role when there has been a registered nurse short. The last such instance was at Christmas and a section 31 advising the Ministry of Health of this was completed.</p> <p>The previously raised corrective action relating to the need to use an acuity tool, as per the policy, to ensure safe staffing levels are met has been addressed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p>	FA	<p>The Medication Management Policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they</p>

<p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse signs in the medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are 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 with controlled drugs signed in. All registered nurses were completing a syringe driver refresher on the day of the audit.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of temperature records taken at the time of the audit.</p> <p>Good prescribing practices were noted. These included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. There are no standing orders or verbal orders. Vaccines are not stored on site. Residents and staff have received the required COVID-19 vaccines and receiving the boosters as per the required time frames.</p> <p>There is a documented process for any residents who are self-medicating. This is decided in conjunction with the GP, registered nurse, and the resident. Self-medication documentation is completed by the GP and accessed every three months.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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 where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site with a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician in October 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Cater Plus Multi Site Food Control Plan, issued 1st January 2022. At the time of the audit, the kitchen was observed to be clean. The cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan using an electronic recording system.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides a varied menu which supports residents' specific needs. The main meal is served in the evening in accordance with residents' preferred choice. Special equipment to meet residents' nutritional needs, was available.</p> <p>There are snacks available twenty hours a day for residents, with a selection of fruit, baking and trays of sandwiches also made. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those</p>

		requiring assistance had this provided.
<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>	FA	<p>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The practice nurse liaison interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the GP practice should a resident's condition change. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources were available and suited to the levels of care provided and in accordance with the residents' needs.</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>	FA	<p>The activities programme is provided is by two part time qualified diversional therapists and a part time activities assistant. They support the rest home and hospital residents Monday to Friday 10.00 am till 4.00 pm. Activities are left set up for the residents over the weekend with the assistance of the care staff.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated by daily observation to see levels of participation and documented in the progress notes and forms part of a six-monthly multidisciplinary care plan review.</p> <p>It is the aim of the diversional therapists and activities assistant to get the residents engaging in the community as much as possible. There is a facility van available for drives on a Thursday for rest home and hospital residents.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'Housie', games, exercises and visiting entertainers. Hospital and rest home residents have the same activity programme. There are several lounge areas, as well as the individual's bedrooms where they can watch their own television or listen to the radio. The Activities Calendar is on display and each resident is given a copy of the weekly activities available for them to participate in.</p> <p>Residents and families can evaluate the programme through day-to-day discussions with the diversional therapist and by completing the resident satisfaction survey and at the six monthly multi-disciplinary meeting. Residents interviewed confirmed the programme was interesting and varied.</p>
Standard 1.3.8:	FA	Resident care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>reassessment and the multidisciplinary team meeting, or as the residents' needs change. The RN documents evaluations. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans are consistently reviewed for infections, pain, weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting 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>	<p>FA</p>	<p>A current building warrant of fitness with an expiry date of 27 January 2023 is publicly displayed near the front entrance. There have been no modifications to the buildings since the last audit.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract, and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at staff meetings and during shift handovers. A good supply of personal protective equipment was available, Terrace View Retirement Village has processes in place to manage the risks imposed by COVID-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of</p>	<p>FA</p>	<p>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.</p> <p>The clinical nurse manager is the restraint coordinator. This person described their familiarity and understanding of the organisation's policies, procedures and practice and their role and responsibilities should enabler or restraint</p>

<p>restraint is actively minimised.</p>		<p>use become an option for a resident.</p> <p>On the day of audit, there were no residents using either a restraint or an enabler. One person who is no longer in the service was using bedrails as an enabler until they were no longer needed. Records of the monitoring of these were available and the clinical nurse manager and staff interviewed confirmed the use of bedrails was the person's choice.</p> <p>Restraint is reportedly used as a last resort when all alternatives have been explored. There has been no use of restraint since at least prior to the last audit.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Over the past year, meeting minutes, verbal reports and completed internal audit results verified that areas requiring improvement had been identified. Examples of actions taken for some of these were verbally reported by various staff during the audit. The electronic corrective actions log that had previously been used for recording remedial actions taken until they were closed out had not been used during 2021.</p> <p>Multiple staff changes, including almost a completely new team of registered nurses, a change of clinical nurse manager and the demands of the COVID-19 pandemic requirements had placed pressure on the managers and staff and had reportedly contributed to this shortcoming. There is a need for the service provider to reinstate the corrective action system and recommence use of the corrective log.</p>	Areas identified as requiring improvement are not being managed through the corrective action plan processes as described within the quality and risk management system.	<p>Corrective action plans are formally developed to address areas requiring improvement. These are logged within the recording system and documented follow-up actions demonstrate that all requirements of the Standards and of accepted best practice are consistently met.</p> <p>180 days</p>
Criterion 1.2.7.5	PA Moderate	Staff training records in human resource files, a 2022 training schedule and training session attendance records were reviewed.	The current training recording systems do	Implement a recording system to ensure that all

<p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>These demonstrated training is being made available; however, it was difficult to ascertain the level of uptake. Examples of low attendances at some mandatory training sessions and records in staff files showing minimal or no training since the last audit were viewed. A previously used staff training spreadsheet has not been used since 2020 and neither staff nor managers could provide any other form of evidence to verify mandatory training requirements are being completed by all staff within the expected timeframes. The corrective action raised at the last audit remains open.</p> <p>Also, staff files of healthcare assistants that were reviewed did not have an up to date performance appraisal in them, which is a policy requirement. The clinical nurse manager confirmed they are overdue, noted that there has not been time to complete these over the five months since taking over the role but provided assurances that there is a plan to ensure these are undertaken in the coming months. Those for registered nurses have been completed.</p>	<p>not verify that service providers have completed training or training updates on mandatory topics to meet contractual requirements. Healthcare assistants have not completed performance appraisals that are required annually.</p>	<p>staff have completed the defined training requirements. Ensure all staff have a performance appraisal completed annually.</p> <p>90 days</p>
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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.