

# Elsdon Enterprises Limited - Annaliese Haven Rest Home

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

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 0.4 of the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

You can view a full copy of the standard on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Elsdon Enterprises Limited
<b>Premises audited:</b>	Annaliese Haven Rest Home
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 24 May 2022    End date: 25 May 2022
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	56

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six sections contained within the Ngā Paerewa Health and Disability Services Standard:

- ō tatou motika | our rights
- hunga mahi me te hanganga | workforce and structure
- ngā huarahi ki te oranga | pathways to wellbeing
- te aro ki te tangata me te taiao haumarū | person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita | infection prevention and antimicrobial stewardship
- here taratahi | restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. 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 subsections applicable to this service fully attained with some subsections exceeded
	No short falls	Subsections 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 subsections 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 subsections 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 subsections applicable to this service unattained and of moderate or high risk

## General overview of the audit

Elsdon Enterprises Limited are the owners of Annaliese Haven Rest Home. There are two owners, one of whom is the CEO. Annaliese Haven Rest Home provides rest home, rest home dementia and hospital level care for up to 61 residents. There are 62 rooms with one set aside for any potential private paying resident. Their last audit was a partial provisional audit in 2020 for the conversion of 21 rest home beds to dual purpose beds. A new facility manager and a senior registered nurse (RN) became the clinical nurse manager in August 2021. There have been no structural facility changes since the previous audit.

This certification audit was undertaken against the new Nga Paerewa standard and the requirements of the DHB contract. The process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, whānau, managers, staff, a pharmacist and a general practitioner.

Six areas requiring improvement were identified. These relate to the need for analysis of quality and clinical data, staffing, currency of care plans, medication management, maintenance, and an infection control practice.

A strength of the organisation is the dedication of the staff to their residents.

## Ō tatou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.

Subsections applicable to this service fully attained.

Annalise Haven Rest Home has processes which support residents including their individual needs. Training has occurred on the Te Tiriti o Waitangi and Māori supports. Pacific peoples are provided with safe services.

Residents and their whānau are informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code) and these are upheld. Personal identity, independence, privacy and dignity are respected and supported. Residents are safe from abuse.

Residents and whānau receive information in an easy to understand format and feel listened to and included when making decisions about care and treatment. Open communication is practised. Interpreter services are provided as needed. Whānau and legal representatives are involved in decision making that complies with the law. Advance directives are followed wherever possible.

Complaints are resolved promptly and effectively in collaboration with all parties involved.

## Hunga mahi me te hanganga | Workforce and structure

<p>Includes 5 subsections that support an outcome where people receive quality services through effective governance and a supported workforce.</p>		<p>Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk</p>
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The CEO receives reports from the facility manger related to the delivering of services. They are aware of the requirements to include meaningful inclusion of Māori in governance groups, honouring Te Tiriti and reducing barriers to improve outcomes and equity for Māori, Pacific people and people with disabilities.

The business plan described the mission, scope, direction, objectives and values for the organisation. Minutes of meetings showed performance is monitored and reviewed. The quality and risk management system focused on improving service delivery and care. Residents and families provide regular feedback. Actual and potential risks are identified and mitigated.

Adverse events are documented with corrective actions implemented. The service complies with statutory and regulatory reporting obligations.

Staffing levels and skill mix are detailed to meet the cultural and clinical needs of residents. Staff are appointed, orientated, and managed using current good practice. A systematic approach to identify and deliver ongoing learning supports safe service delivery.

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

## Ngā huarahi ki te oranga | Pathways to wellbeing

Includes 8 subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
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When people enter the service a person-centred and whānau-centred approach is adopted. Relevant information is provided to the potential resident and their whānau.

The service works in partnership with the residents and their whānau to assess, plan and evaluate care. Care plans are individualised, based on comprehensive information and accommodate any new problems that might arise. Files reviewed demonstrated that care meets the needs of residents and whānau and is evaluated on a regular and timely basis.

Residents are supported to maintain and develop their interests and participate in meaningful community and social activities suitable to their age and stage of life.

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

The food service is safely managed and considers the cultural needs of residents.

Residents are referred or transferred to other health services as required.

## Te aro ki te tangata me te taiao haumaruru | Person-centred and safe environment

<p>Includes 2 subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.</p>		<p>Some subsections applicable to this service partially attained and of low risk</p>
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The facility meets the needs of residents and was clean and calm and the environment was warm. There was a current building warrant of fitness. Electrical equipment has been tested as required. External areas are accessible and provide shade and seating, which allows residents with dementia and mobility issues with an appropriate gated outside area.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Staff, residents and whānau understood emergency and security arrangements. Residents reported a timely staff response to call bells. Security is maintained.

## Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

<p>Includes 5 subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.</p>		<p>Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk</p>
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The governing body ensures the safety of residents and staff through a planned infection prevention (IP) programme. There is an infection control programme that is appropriate to the size and complexity of the service. It is adequately resourced. An experienced and trained infection control coordinator leads the programme.

The infection control coordinator is involved in procurement processes, any facility changes, and processes related to decontamination of any reusable devices.

Staff demonstrated good principles and practice around infection control. Staff, residents and whānau were familiar with the pandemic/infectious diseases response plan and enacted this successfully through a recent Covid-19 outbreak.

Aged care specific infection surveillance is undertaken with follow-up action taken as required.

The environment supports prevention and transmission of infections. Waste and hazardous substances are well managed. There are safe and effective laundry services.

## Here taratahi | Restraint and seclusion

Includes 4 subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service fully attained.
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Annaliese Haven Rest Home has been a restraint free environment since 2018. This is supported by the governing body, policies and procedures. Staff and management confirmed this is a restraint free environment. There are policies and processes available in the electronic patient record should staff ever have need to undertake restraint.

## Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	19	0	3	4	0	0
Criteria	0	125	0	3	4	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)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

# Attainment against the Ngā Paerewa Health and Disability Services Standard

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

There may be subsections in this audit report with an attainment rating of ‘not applicable’ which relate to new requirements in Ngā Paerewa that the provider is working towards. The provider will be expected to meet these requirements at their next audit.

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

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	<p>FA</p>	<p>There is a Māori and Pacific Health Plan and Ethnicity Awareness Policy which recognises the Te Tiriti o Waitangi, te whare tapa wha and mana motuhake. This is available for staff but has yet to be embedded into the service. The signage around the facility includes the Māori names as well as English. Contact with local kapa haka group and marae has occurred, via the diversional therapist’s work.</p> <p>The facility manager and clinical nurse manager have recently undertaken cultural and Te Tiriti o Waitangi training. The facility manager provided training for staff which included Te Tiriti and te whare tapa wha and specific care needs for Māori residents. Staff spoke of treating all residents with respect, including cultural aspects of care. There was one resident who had Māori heritage but did not wish anything specific related to their Māori heritage.</p> <p>In speaking with the chief executive officer (CEO) and the facility managers they recognise that they have some work to do in relation to engagement with Māori and embedding the Te Tiriti and equity</p>

		strategies into the organisation.
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p> <p>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.</p> <p>As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.</p>	Not Applicable	<p>As stated above, the organisation has a policy which covers Pacific peoples. This is yet to be embedded.</p> <p>The manager discussed the need to work in partnership with Pacific communities and organisations to provide assistance with supporting culturally safe practices for Pacific peoples using the service. One resident who identifies as Pacific, had their needs considered with input from the family. However, they did not have any specific Pacific needs. This was confirmed by the resident and whānau.</p>
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>Staff interviewed understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents in accordance with their wishes.</p> <p>Residents and whānau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) and were provided with opportunities to discuss and clarify their rights.</p> <p>Not all staff understand the concept of mana motuhake and the service is providing education on this.</p>
<p>Subsection 1.4: I am treated with respect</p> <p>The People: I can be who I am when I am treated with dignity and respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake.</p> <p>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their</p>	FA	<p>The service supports residents in a way that is inclusive and respects their identity and experiences. Residents and whānau, including people with disabilities, confirmed that they receive services in a manner that has regard for their dignity, gender, privacy, sexual orientation, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room, although one married couple have chosen to share their rooms and utilise one room as a bedroom and</p>

<p>experiences.</p>		<p>one as a living area to maintain their normal life patterns.</p> <p>Te reo Māori and tikanga Māori are promoted within the service through policy and education of staff. Bilingual signage is used within the facility and key resident information such as the Code of Rights is displayed in te reo Māori</p>
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	<p>FA</p>	<p>Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Residents reported that their property is respected. Professional boundaries are maintained.</p> <p>The staff is multicultural and those interviewed stated they felt comfortable to question any racism they encountered.</p> <p>Care provision is holistic encompassing the pillars of ‘Te Whare Tapa Whā’, and is based on the identified strengths of residents. Wellbeing outcomes are evaluated as part of the assessment and care planning process six monthly to ensure the needs of residents are met.</p>
<p>Subsection 1.6: Effective communication occurs</p> <p>The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing.</p> <p>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.</p> <p>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.</p>	<p>FA</p>	<p>Residents and whānau reported that communication was open and effective, and they felt listened to. Information was provided in an easy to understand format. Communication with relatives/whānau is a strength of the service with changes to residents’ health status being communicated to relatives/whānau in a timely and comprehensive manner, as confirmed through interview and review of files. Appropriate communication with other health professional involved in a resident’s care, for example the general practitioner, was evident and detailed.</p> <p>Staff knew how to access interpreter services, if required.</p>
<p>Subsection 1.7: I am informed and able to make choices</p> <p>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that</p>	<p>FA</p>	<p>Residents and/or their legal representative are provided with the information necessary to make informed decisions. Residents and whānau interviewed stated they felt empowered to actively participate in decision making. Nursing and care staff interviewed understood the principles and practice of informed consent and described involving</p>

<p>supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p> <p>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.</p>		<p>whānau in the process.</p> <p>Advance directives, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent are documented, as relevant, in the resident's record.</p> <p>Two residents in the secure dementia unit have a court appointed welfare guardian, all other residents' in the secure dementia unit have a documented enduring power of attorney on file that has been activated by an appropriate medical practitioner.</p>
<p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p> <p>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>	<p>FA</p>	<p>A fair, transparent system is in place to receive and resolve complaints. There have been no complaints recorded since August 2021 and few prior to this time. The service receives many compliments and positive feedback about their service.</p> <p>The complaints reviewed from early 2021 showed the complaints management complied with the Code, investigation had occurred and any areas for improvement had occurred. Documentation sighted showed that complainants had been informed of findings following investigation. The facility manager is responsible for complaints management and was aware of the Code requirements.</p> <p>Forms to make a complaint are given to residents and whānau prior to admission and these are also available at the reception, beside a suggestion box.</p> <p>Residents and whānau understood their right to make a complaint and knew how to do so. They were complimentary of the facility manager's 'open door' policy and availability to talk to them if they had an issue. This was observed during the audit.</p> <p>There was one complaint received from the HDC, in August 2021. This has been responded to with the information requested by the HDC provided in the same month. The provider is waiting to hear back from the HDC on their findings.</p>

<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a high-quality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>FA</p>	<p>The owners assume accountability for delivering a high-quality service through the delegated work and reporting of the facility manager. They are aware of their legislative and contractual requirements for reporting to external bodies, and through membership of the New Zealand Aged Care Association, maintain currency within the field. A policy is in place covering clinical governance and the CEO/owner has access to clinical advice outside the facility. The clinical governance in the facility falls to the clinical nurse manager.</p> <p>There is an Annaliese Haven business plan 2020 – 2022 which states the mission, described the environment in which service providers work, and includes a strengths, weaknesses, opportunities and threats (SWOT) analysis. The plan outlines their scope, direction, objectives and values for the organisation. The facility manager reviewed this document in August 2021 and was yet to look at their progress against this document before commencing their next business plan.</p> <p>The facility manager is suitably qualified, with many years' experiences in management of aged residential care. They have undertaken training in management in their past roles. They stated they have a current job description and agreement, as this was not available to sight during the audit.</p> <p>The CEO and manager are aware of the need to support meaningful inclusion of Māori in governance groups and honouring Te Tiriti o Waitangi and provide documentation on improving outcomes for Māori and people with disabilities. This is work that is still to be done,</p> <p>The facility manager provides financial reports to the CEO on a monthly basis and stated that they were meeting regularly in person prior to their COVID-19 outbreak and are in daily contact by email and phone.</p> <p>There are 62 rooms within the facility, 61 of which have been agreed for occupancy by the Ministry. The organisation holds DHB contracts for Aged Related Residential Care for rest home, dementia and hospital care. On the first day of audit there were 57 residents, 12</p>
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		<p>receiving hospital level care, 19 receiving rest home care and 19 receiving dementia level care. The organisation also holds contracts for long term chronic health conditions, respite and support of end of life, there were no residents under these contracts during the audit.</p>
<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>	<p>PA Moderate</p>	<p>The organisation uses an external contracted provider for the templates used in its quality and risk management system, including policies and procedures. This includes an audit matrix, covering clinical and non-clinical areas, incident reporting, infection reporting, complaints and a risk register. Resident and whānau satisfaction surveys are undertaken at least annually with the last one occurring in October 2021. New residents are also surveyed after three months, and respite residents complete a survey at the end of their stay. Examples of these showed a high degree of satisfaction with the services being delivered. Food service audits showed on the whole satisfaction with meals being provided. Where an issue is raised this had been investigated and resolved. Monthly residents' meetings occur and showed input from the residents.</p> <p>Results of audits were sighted and showed good compliance to systems, although the documentation on the tool, was unclear and this will be rectified at the next audit. The results of audits, incidents, infections are discussed at the quality team and staffing meetings. Health and safety meetings occur and the minutes showed review of audit results and discussion on the risks in the different areas of the facility. However, analysis and trending of the data are currently not occurring. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Policies reviewed as part of stage one of the audit showed they covered all necessary aspects of the service and contractual requirements and good practice with relevant references. These were current.</p> <p>The facility manager described the processes for the identification, documentation, monitoring, review and reporting of risks, including health and safety risks, and development of mitigation strategies. Review of the organisation's risk register confirmed the process and</p>

		<p>how new risks are added.</p> <p>Staff document adverse and near miss events electronically in line with the organisation's policy. The events sighted related mostly to clinical events, such as falls, pressure injuries, skin tears and medication errors. These were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Each incident is reviewed at the monthly quality meeting. There were no residents who identified as Māori. The need to keep ethnicity data related to adverse events was discussed with the facility manager.</p> <p>The CEO and facility manager understood and have complied with essential notification reporting requirements. No police investigations, coroner's inquests, or issues-based audits have occurred since the last audit. Notification on a COVID-19 outbreak has occurred - Refer section 5.</p> <p>The organisation has still to identify barriers to high quality care for Māori and to critically analyse equity and its meaning for the organisation.</p>
<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	<p>PA Low</p>	<p>There is a documented policy for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). The facility has increased its hospital level residents which has not been reflected in the roster, and other areas are showing signs of staffing having insufficient time to carry out their work. Care staff reported they felt they were providing a safe service but did not have adequate staff to complete the work allocated to them. Residents and whānau interviewed did not raise concerns about staffing levels. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital. Staff report management being approachable and attend staff meetings.</p> <p>Continuing education is planned on an annual basis, including mandatory and competency training requirements. Related competencies are assessed and support equitable service delivery. The majority of care staff have either completed or commenced a</p>

		<p>New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. Staff working in the dementia care area have either completed or are enrolled in the required education. Certificates for the 29-care staff were sighted as follows:</p> <p>NZQA level 4 - 13</p> <p>NZQA level 3 - 3</p> <p>NZQA level 1 -11, six of whom have started within the last year and five have been employed for a longer period and have indicated they do not wish to undertake NZQA study. Two certificates requested from staff were still pending.</p> <p>Records reviewed demonstrated attendance at the annual training requirements including competencies.</p> <p>The organisation has yet to establish how they will encourage staff in learning opportunities related to recent Māori health outcomes and te reo Māori, as well as how they will develop an understanding of health equity with their staff.</p>
<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice, relevant legislation and contained references for managers to follow.</p> <p>A sample of nine staff records reviewed (three caregivers, the diversional therapist, maintenance, administration, two RNs and a cook) confirmed the organisation's policies are being implemented.</p> <p>Staff performance reviews were all undertaken by the last facility manager in August 2021, and the present manager is looking at how these will be done this year.</p> <p>All staff personnel files were seen to be kept safe and confidentiality is maintained. The facility manager is aware of the ethnicity of most of her staff, however there is no formal process for recording this and</p>

		<p>this is recommended to occur going forward.</p> <p>All health professionals had a current annual practising certificate.</p>
<p>Subsection 2.5: Information</p> <p>The people: Service providers manage my information sensitively and in accordance with my wishes.</p> <p>Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity.</p> <p>As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' eight files sampled for review. Clinical notes are all electronic and were current, integrated and legible and met current documentation standards.</p> <p>Residents' files are held securely for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Subsection 3.1: Entry and declining entry</p> <p>The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p> <p>As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.</p>	FA	<p>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. Residents and whānau members are invited to visit the facility prior to admission and those interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission, including for a resident who identifies as Pacifica. Files reviewed met contractual requirements.</p> <p>All residents admitted to the secure dementia unit have a specialist assessment and referral prior to admission and files show their EPOA has consented to the admission.</p> <p>A wait list is maintained when the service is unable to accommodate a resident immediately and the manager provides updates to prospective residents and their whānau. Where a prospective resident is declined entry, there are processes for communicating the decision. Related data is documented and analysed. However, ethnicity data is not collected prior to admission. The service does not yet analyse entry and decline data for Māori and is taking steps to achieve this.</p> <p>There are no current residents who identify as Māori and no residents</p>

		<p>have requested the services of a Māori health practitioner or traditional Māori healer. The service is working to establish links to enable this to occur when needed.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>PA Moderate</p>	<p>The multidisciplinary team work in partnership with the resident and whānau to support wellbeing. A care plan is developed by suitably qualified staff following a comprehensive assessment, including consideration of the person's lived experience, cultural needs, values and beliefs, and considers wider service integration, where required.</p> <p>Assessment is based on a range of clinical assessments and includes resident and whānau input. Initial assessment, medical practitioner assessment, and initial care plans are completed on admission and include identification and consideration of cultural needs, values and beliefs. Short term care planning is completed for new problems that arise, such as infections. However, interRAI assessment and completion of long-term care plans and review timeframes do not meet contractual requirements for residents. This was verified by sampling residents' records, from interviews, including with the GP, and from observations.</p> <p>Management of any specific medical conditions were well documented with evidence of systematic monitoring and regular evaluation of responses to planned care. This included identification of residents whose conditions were deteriorating. Where progress is different to that expected, medical assessment and allied health input is sought if necessary and changes are made to the care plan in collaboration with the resident and/or whānau. Residents and whānau confirmed active involvement in the process, including for elderly residents with age related disability.</p> <p>The long term care plan for residents in the secure dementia unit contains behaviour management strategies and interventions for behavioural needs.</p> <p>There were no residents who identified as Māori. Not all staff understand fully the needs of Māori related to pae ora outcomes.</p>

<p>Subsection 3.3: Individualised activities</p> <p>The people: I participate in what matters to me in a way that I like.</p> <p>Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.</p> <p>As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.</p>	<p>FA</p>	<p>A trained diversional therapist, and an activities coordinator assistant provide an activities programme that supports residents to maintain and develop their interests and was suitable for their ages and stages of life.</p> <p>A resident profile and cultural assessment identify individual resident's interests and consider the person's identity, beliefs and culture. Individual and group activities reflected residents' goals and interest, ordinary patterns of life and included normal community activities.</p> <p>There were no residents who identify as Māori at the time of audit. Opportunities for Māori and whānau to participate in te ao Māori were discussed and the activities team gave examples of what could occur and actions they would take however, no evidence was seen that this has occurred. Staff are not currently involved in community activities for Māori and are considering how the workforce can become involved.</p> <p>Residents in the dementia unit have meaningful activities planned over a 24-hour period and the activities team leave activities available for carers to use when they are not present. However, carers reported that due to workload they are not able to provide activities when the dedicated activities team is not present. This is raised as a corrective action under criterion 2.3.1.</p> <p>Residents and whānau are involved in evaluating and improving the programme through satisfaction surveys. Those interviewed confirmed they find the programme meets their needs.</p>
<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>As service providers: We ensure people receive their medication</p>	<p>PA Moderate</p>	<p>The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit, including the recording of allergies and sensitivities. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility from a contracted pharmacy. Medication reconciliation occurs. All medications sighted were within</p>

<p>and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>current use by dates. However, not all eye drops and ointments with a limited shelf life once opened had the date of opening (or expiry date) recorded.</p> <p>Medicines are stored safely, including those requiring refrigeration. Medicines stored were within the recommended temperature range. However, not all opened ointments were stored with a cap or nozzle in place.</p> <p>Controlled drugs are securely stored and the required stock checks for controlled drugs have been completed.</p> <p>Prescribing practices meet requirements, including consideration of over the counter medications. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>Self-administration of medication is facilitated and managed safely.</p> <p>Residents and their whānau, are supported to understand their medications. There were no residents who identify as Māori present at the time of audit, but staff discussed including whānau in decision making and the use of traditional Māori medicines if requested.</p>
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	<p>PA Low</p>	<p>A menu is provided by a qualified dietitian which follows the nutritional guidelines of older people. However, the cook has made changes to this menu which have not been approved by the dietitian. As a result, the service is unable to confirm that the food service is in line with recognised nutritional guidelines for older people. The menu in use is varied, and residents are satisfied with the food served.</p> <p>All aspects of food management comply with current legislation and guidelines. The service operates with an approved food safety plan and registration.</p> <p>Each resident has a nutritional assessment on admission to the facility. The personal food preferences, any special diets and modified texture requirements are accommodated in the daily meal</p>

		<p>plan. All residents have menu options that meet their requirements. There are no foods on the menu culturally specific to te ao Māori, however, staff stated that all residents are asked their preferences and the cultural requirements of Māori would be accommodated.</p> <p>Snacks such as biscuits, sandwiches and hot drinks are available 24 hours a day in the secure dementia unit.</p> <p>Residents were given sufficient time to eat their meals in an unhurried fashion and those requiring assistance had this provided with dignity.</p> <p>Evidence of resident satisfaction with meals was verified by residents and family interviews, satisfaction surveys and resident meeting minutes. A food services satisfaction survey completed in October 2021 indicated not all residents felt they had sufficient opportunity to contribute to the menu.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</p> <p>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.</p>	FA	<p>Transfer or discharge from the service is planned and managed safely with coordination between services and in collaboration with the resident and whānau. Residents and whanau are informed of their options to access other health and disability providers.</p> <p>Whānau reported being kept well informed during the transfer of their relative. This was verified in the hospital level care tracer review and review of a resident discharged to the community.</p>
<p>Subsection 4.1: The facility</p> <p>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.</p>	PA Low	<p>Annaliese Haven have a part time maintenance person who started in March 2022, who carries out checks on the environment and attends to any issues via a maintenance book. The manager has a list of maintenance which is undertaken by external contractors. This ensures the residents' physical environment and facilities (internal and external) are fit for their purpose, included an appropriate area for</p>

<p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>		<p>residents with dementia, and that they meet legislative requirements. The building had a current building warrant of fitness, expiry 23 July 2023.</p> <p>The building is old and is being maintained, a recent internal environmental review was undertaken and identified areas for work. This was observed during the audit and is identified as an area for improvement.</p> <p>The environment was comfortable and accessible, promoting independence and safe mobility. Room sizes vary, but there was adequate room in the sample of rooms observed for staff to move around to assist residents using equipment.</p> <p>All rooms have external opening windows for ventilation. Heating is provided by a variety of methods including underfloor heating and wall mounted heaters.</p> <p>There were a number of areas where residents can relax, sit in small and larger groups for private conversations or to undertake activities and dining areas. This was observed in both the rest home/hospital and dementia areas. There is a fenced external area to allow residents with dementia to walk around safely.</p> <p>Personalised equipment was available for residents with disabilities to meet their needs. There are a variety of room types some with ensuite consisting of toilet and handbasin and others with toilet, shower and handbasins. Toilets are also in close to dining/sitting rooms. There was adequate numbers of accessible bathroom and toilet facilities throughout the facility.</p> <p>Residents and whānau were happy with the environment, including heating and ventilation, privacy and maintenance. Residents and whānau are consulted and involved in the design of any new buildings.</p> <p>Spaces were culturally inclusive and suited the needs of the resident groups. How the environment will reflect the aspirations and identify</p>
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		of Māori has yet to be decided.
<p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p>	FA	<p>The facility has a record of an application to Fire and Emergency New Zealand in 2011 for an update to their fire evacuation plan which has been actioned and enacted since then. The plan takes into account the needs of the residents with dementia. There are regular fire drills occurring, the last in February 2022 which included fire warden training. There is at least one staff member on each duty who has a current first aid certificate.</p> <p>Policies and emergency flip charts are available for staff for a range of possible disasters. Adequate supplies for use in the event of a civil defence emergency are in place and meet The National Emergency Management Agency recommendations for the region. Staff have been trained and knew what to do in an emergency.</p> <p>Call bells alert staff to residents requiring assistance. Residents and whānau reported staff respond promptly to call bells. Appropriate security arrangements are in place.</p> <p>Residents were familiar with emergency and security arrangements.</p>
<p>Subsection 5.1: Governance</p> <p>The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately.</p> <p>Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance.</p> <p>As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.</p>	FA	<p>The Infection Prevention and Anti-microbial Stewardship and Health and Safety Programme Manual acknowledges Te Tiriti and Te Whare Tapu Wha; however, there is nothing to indicate the governance role in the programme.</p> <p>Expertise and advice are sought from the DHB Infection Prevention Team following a defined process. A documented pathway supports reporting of progress, issues and significant events to management, however, there is nothing to indicate this includes reporting to the governing body.</p> <p>A pandemic/infectious diseases response plan is documented and was utilised through an outbreak of Covid-19 in March/April 2022. There are sufficient resources and personal protective equipment (PPE) available, and staff have been trained accordingly.</p>

<p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	<p>PA Moderate</p>	<p>The infection prevention and control coordinator (IPCC) is responsible for overseeing and implementing the IP programme with reporting lines to the facility manager. The IPCC has appropriate skills, knowledge and qualifications for the role and confirmed access to the necessary resources and support. Their advice has been sought when making decisions around procurement relevant to care delivery, design of any new building or facility changes, and policies.</p> <p>The infection prevention and control policies written with input from a qualified infection prevention specialist reflected the requirements of the standard and were based on current accepted good practice. However, there were no procedures related to the decontamination and disinfection of medical instruments. Single use items were reused and reusable instruments used for wound care not appropriately decontaminated and disinfected, see CAR 5.2.3..</p> <p>There is a Pandemic Plan in place and the service has sufficient stores of personal protective equipment available (PPE).</p> <p>Education is provided to all staff at orientation and in ongoing online learning and face to face sessions. Education has included a focus on Covid-19, Hand Hygiene, and the donning and doffing of PPE.</p> <p>Staff were familiar with policies through education during orientation and ongoing education and were observed to follow these correctly. Residents and their whānau are educated about infection prevention in a manner that meets their needs.</p> <p>Cultural advice is accessed where appropriate and the service is considering how to engage in partnership with Māori to ensure practices are culturally safe. There are no educational resources available in te reo Māori.</p>
<p>Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation</p> <p>The people: I trust that my service provider is committed to</p>	<p>FA</p>	<p>Responsible use of antimicrobials is promoted. The GP monitors antimicrobial prescribing in their practice. However, the overall effectiveness of the AMS programme is not evaluated to identify areas for improvement. The pharmacist and GP interviewed were happy to be a part of AMS monitoring and evaluation in partnership with the</p>

<p>responsible antimicrobial use.</p> <p>Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant.</p> <p>As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.</p>		<p>facility.</p> <p>There is nothing to indicate the involvement of the governing body has approved the AMS programme.</p>
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p>	FA	<p>Surveillance of health care-associated infections (HAIs) is appropriate to that recommended for long term care facilities and is in line with priorities defined in the infection control programme. Standardised definitions are used to identify infections. Monthly surveillance data is collated, with the exception of ethnicity data. Minimal analysis occurs; however, the facility has noted the increase in urinary infections occurring and is looking at possible causative factors and required actions. This may have been identified earlier if the facility had an established data analysis/trending programme, refer to corrective action raised under Standard 2.2.2 Results of the surveillance programme are shared with staff.</p>
<p>Subsection 5.5: Environment</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.</p> <p>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible.</p> <p>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobial resistant organisms.</p>	FA	<p>The environment was seen as being clean and hygienic, with a few issues identified (see CAR 4.1.2).</p> <p>Staff follow documented policies and processes for the management of waste and infectious and hazardous substances, and this is removed by a contracted provider. Laundry and cleaning processes are monitored for effectiveness. The only washing machine in the laundry is not suitable for woollens and this is clearly marked on it, which means staff have to handwash these items. Some residents' family members take these items home for washing. Staff involved have completed relevant training and were observed to carry out duties safely. Chemicals were stored safely.</p> <p>Residents and whānau reported that the laundry is managed well, and the facility is kept clean and tidy. This was confirmed through</p>

		observations.
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>	FA	<p>Maintaining the restraint free environment is the aim of the service. The CEO, manager and staff spoke of a commitment to this. There have been no restraint episodes since 2018. Staff in the dementia unit were observed using calming and distraction techniques with residents. The organisation would report to the CEO if there was any restraint episode.</p> <p>Policies and procedures meet the requirements of the standards. The clinical nurse manager has the role of the restraint coordinator and has a job description related to this role. Staff have training annually related to restraint minimisation and will ensure cultural-specific interventions and de-escalation techniques are included. Staff who work in the dementia unit have undertaken or are working towards NZQA dementia training. This was confirmed by staff working in the area.</p> <p>Review of the 2018 restraint folder showed processes were in place for good practice. The electronic policy and procedures include forms for restraint use if required. The patient management system has an area where restraint would be documented if it occurred. This allows for linkage with the incident management system.</p>

## Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our 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 2.2.2</p> <p>Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.</p>	PA Moderate	<p>There was evidence of the elements of a quality framework being in place to reduce risks to the organisation and improve service delivery and care. The use of the electronic reporting system allows data to be collected and analysed. The minutes of the quality meeting showed the data being reviewed by the senior staff. Data sighted included:</p> <ul style="list-style-type: none"> <li>- the individual incident reports and actions taken</li> <li>- infections for the individual resident and actions taken</li> </ul> <p>There was no reporting on the analysis of the data being collected and documented in the minutes of the quality meetings. The list of incidents and infections were attached to the meeting minutes. However, there was no documented analysis of the numbers of</p>	<p>The service has a quality framework which includes clinical incident reporting, such as falls, skin tears, pressure injuries, resident and whanau satisfaction surveys and infection prevention data. The data is reviewed month on month, however there is no analysis being carried out on the data.</p>	<p>Quality data collected is analysed to ensure the steps being taken are making a difference to patient outcomes. This includes trends for individuals where applicable, and with types of incidents over time.</p> <p>90 days</p>

		incidents or infections by type, by resident, or trending to show if there was an increase or decrease over the last year, or years. During the audit the manager was able to provide a graph over time for incidents, but this is not a regular activity. There was no benchmarking occurring with other Elsdon Enterprise facilities or similar providers outside the organisation.		
<p>Criterion 2.3.1</p> <p>Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.</p>	PA Low	<p>The organisation has provided hospital level services for up to 21 residents since 2020. Staff reported staffing levels have been fluctuating due to staff leaving, and there has been a new facility manager and clinical nurse manager since August 2021. The facility had a COVID-19 outbreak, commencing in March 2022 which was cleared on the 6 May 2022. During the outbreak staff numbers declined, due to staff requiring isolation at home. The local DHB provided support which was highly appreciated. Since then, the rosters reviewed showed that not all duties were able to be covered in both the rest home hospital areas and dementia unit. Examples sighted were:</p> <ul style="list-style-type: none"> <li>- The clinical nurse manager and other RN doing double shifts (two sighted)</li> <li>- In the dementia unit, three, three hour shifts not being filled.</li> <li>- The areas which have rest home and hospital residents had two duties not covered on the afternoon</li> <li>- Examples of staff doing over their usual</li> </ul>	<p>Staff reported feeling under pressure with the increase in the numbers of hospital level care residents.</p> <p>It was noted that the 'floating' person in the dementia wing has not been replaced on several occasions on the roster.</p> <p>The activities programme has reduced with caregivers not being available to provide activities. This is particularly evident in evening and weekends in the dementia unit and for hospital level care residents who do not attend group activities.</p> <p>The laundry hours have been reduced and staff are finding they cannot complete the necessary tasks, such as cleaning the area or folding the linen or putting away stores.</p>	<p>The organisation reviews the number of staffing hours related to their increasing hospital population to ensure staff can give the care they require. The activities programme be reviewed to ensure it is meeting the needs of the residents and in particular in the dementia wing. Review of the tasks undertaken by the laundry staff in the hours they now have.</p> <p>90 days</p>

		<p>hours, for example staying on over their normal hours or doing extra shifts.</p> <p>Staff reported that these examples are not new, and they do not have sufficient staff to manage the increase the extra workload of the hospital and dementia residents. The senior RN and facility manager confirmed the numbers of hospital level patients has increased, with three more being assessed as hospital level recently. These were a mix of new and reassessed residents. All hospital level care residents are requiring two staff to transfer safely, and no change has been made to the rosters to accommodate this. Registered nurses reported they have been unable to meet contractual timeframes for the completion of interRAI assessments and long term care planning due to workload.</p> <p>Review of rosters showed, in the hospital rest home area four care staff on the morning and afternoon, one at night with an RN on all duties. One of the care staff in each area does three hours, leaving at 11 am. This is to care for 12 hospital level and 19 rest home residents.</p> <p>At the time of audit, the data on clinical incidents and infection rates, was not trended over time; however, a graph of incidents completed during the audit, showed an increase in falls and behaviours of concern in April, and the data on infection rates showed marked increase in urinary tract infections.</p> <p>The residents and family members reported no concerns related to staffing numbers and</p>		
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		<p>that call bells were being answered promptly.</p> <p>There has been a review of staffing levels in some areas and staff reported hours have reduced which has put extra pressure on them to complete tasks.</p> <p>The numbers of laundry staff hours have reduced, and it was observed that storage cupboards were dirty. The folding of washing is being left for afternoon staff. The reduced hours have impacted on the workers' ability to complete these tasks. It was observed that carers in the afternoon were folding linen away from residents, reducing the numbers observing and caring for residents.</p> <p>The diversional therapy hours have reduced, and the expectation is that care staff will carry out activities with residents when the diversional therapy team are not onsite, such as evenings and weekends. It was noted that the activities programme has been reduced, including exercise programmes recognised to reduce the numbers of falls. It was noted that dementia patients' care plans include access to activities 24 hour, seven days a week, as a way to assist with behaviour issues. Care staffing levels are insufficient to provide these activities outside the hours the activities team are present</p> <p>The facility manager stated that there were two care staff coming onboard for orientation in the next few weeks. They are advertising for a RN as presently the number of RNs is insufficient to meet the requirements. A bureau RN is being used to cover the roster short falls.</p>		
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<p>Criterion 3.2.1</p> <p>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.</p>	<p>PA Moderate</p>	<p>The personal files of eight residents, including the three tracers, were fully reviewed. The sample was extended by a further seven residents to include all residents admitted in 2022 to verify findings. The files demonstrated that assessment processes including the interRAI assessment are identifying individual resident's needs and informing long and short-term care plans. Interviews with residents and whanau confirmed whanau involvement in the assessment and care planning process. However, short term care planning for a resident recently discharged from hospital (see Hospital Level Tracer) did not include the requirement for thickened fluids and a puree diet and for seven of nine residents admitted in 2022 the interRAI assessment and long-term care plan have not been completed within the contractually required timeframe. A further 17 residents are overdue interRAI reassessment, by up to eight weeks, this is within the deferment time allowed by the Ministry of Health ARC guidance for operating under the Covid-19 framework for facilities with an outbreak of Covid-19. However, no plans are in place to complete these assessments now the outbreak in the facility is over. The registered nurse and clinical nurse manager interviewed stated staffing shortages have prevented completion of these requirements refer Criterion 2.3.1</p>	<p>Not all residents have the required assessments and long-term care planning completed within the contractually required timeframes. Not all short term care plans reflected residents changing needs.</p> <p>A short term care plan for a resident recently discharged from hospital did not include the requirement for thickened fluids and a puree diet</p> <p>For residents admitted in 2022:</p> <p>Six residents have not had an interRAI assessment completed since admission and one resident had an interRAI assessment completed six weeks after the required time.</p> <p>Four residents had a long-term care plan completed later than the required time frame by up to nine weeks, and three residents have not had a long term care plan completed since admission.</p> <p>For residents whose interRAI reassessment was delayed due to the Covid-19 outbreak, there are no plans in place to ensure these are completed in</p>	<p>Take actions to ensure all residents have an interRAI assessment and long-term care planning completed within the contractually required timeframe.</p> <p>90 days</p>
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			a timely manner.	
<p>Criterion 3.4.1</p> <p>A medication management system shall be implemented appropriate to the scope of the service.</p>	<p>PA Moderate</p>	<p>There are documented policies to guide safe practice for all aspects of medication management, including prescribing, storage, administration and disposal. However, not all elements of the medication management system as implemented meet the expected standard to enable safe administration of medications:</p> <p>i) Not all prescribed medication contained a legible label with the required information. This included three ointments and one nasal spray where the label was worn and illegible or absent and the resident's name and administration instructions were not identifiable.</p> <p>ii) The date of opening of eye drops and ointments with a limited shelf life once opened was not recorded for nine creams/ointments, seven eye drops and one nasal spray sighted. This included two creams prescribed in 2020.</p> <p>iii) Two ointments were stored without a cap placed on the nozzle.</p> <p>iv) Two 'spacers' used for the administration of inhaled medications was contained within the medication trolley, one did not have a legible label to identify the resident's name.</p>	<p>Not all elements of the medication management system as implemented meet the expected standard to enable safe administration of medications:</p>	<p>The service will ensure:</p> <p>All medications contain a legible label including the resident's name and required prescription details.</p> <p>The date of opening of eye drops and ointments is recorded.</p> <p>Medication is stored safely with a cap or nozzle replaced on ointments once opened.</p> <p>All individual resident equipment used to administer medication, such as a spacer used for inhaled medication, is labelled to identify the resident.</p> <p>90 days</p>
<p>Criterion 3.5.4</p> <p>The nutritional value of</p>	<p>PA Low</p>	<p>The menu is prepared by a qualified dietitian and accompanied by detailed recipes for the</p>	<p>The service has modified the menu approved by the dietitian</p>	<p>The service ensures the menu followed is approved by a</p>

<p>menus shall be reviewed by appropriately qualified personnel such as dietitians.</p>		<p>cook and kitchen staff to follow. A summer and a winter menu were sighted. However, the cook has stated she makes significant changes to the menu due to resident feedback. The changes made are not subsequently reviewed by the dietitian and the service is unable to confirm the modified menu meets the nutritional needs of the elderly residents. Review of the menu verified significant changes had been made in all food groups which would affect the protein, fibre, carbohydrate and fat content of the menu. Suggestions/recommendations from the dietitian should changes be made had not been implemented.</p>	<p>and is unable to confirm the menu meets the nutritional guidelines for older people.</p>	<p>qualified dietitian  180 days</p>
<p>Criterion 4.1.2  The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence.</p>	<p>PA Low</p>	<p>The facility manager shared an environmental review that had been undertaken recently, which identified areas requiring some repair and maintenance for the organisation. During the audit areas identified included:</p> <ul style="list-style-type: none"> <li>• Chipped doors which require filling and painting, as they could not be cleaned properly.</li> <li>• Storage space is at a premium and cupboards were observed to be full. Stock is being kept on the floor and not easy to move making it difficult for cleaning. In one storage cupboard there was a large amount of dust behind the equipment.</li> <li>• In the dementia unit servery, the serving hatch surround has not been finished. There is bare wood showing, which is not able to be cleaned.</li> </ul>	<p>There are areas where maintenance is required around the facility, such as chipped walls, showers where the wall covering is coming away, delamination of furnishings, and other areas requiring attention identified during a recent internal audit. Another area requiring attention is the laundry, where the vinyl flooring is broken at the coving beside the washing machine. The room behind the drier is used for hanging residents' clothes and staff are in and out of the area, the floor is badly broken and the vinyl covering ripped, making the floor uneven.</p>	<p>Maintenance areas identified by the internal audit and during this audit are attended to to ensure the safety of staff and residents.  180 days</p>

		<ul style="list-style-type: none"> <li>• Two showers were seen to have the wall vinyl coming away from the wall. One internal shower room had poor ventilation which could lead to dampness.</li> <li>• The laundry flooring has cracked coving beside the washing machine, which is an infection control risk. The room behind the drier is used for hanging residents' clothes to finish drying. The concrete floor under the vinyl is badly broken which makes the floor uneven and a potential trip hazard for staff.</li> <li>• The outside garden area, where dementia patients can walk was observed to need some trimming as the vegetation was growing onto the path and has the potential to trip a patient or staff member.</li> <li>• Some rooms have heaters fixed high up on the wall. These were sighted as causing black smoke marks on the ceiling, which could indicate a problem. This should be investigated.</li> </ul>		
<p>Criterion 5.2.3</p> <p>Service providers shall develop written IP policies with input from suitably qualified personnel, which comply with relevant legislation and accepted best practice. The suite of policies shall include:</p> <p>(a) Hand hygiene and standard precautions;</p>	<p>PA</p> <p>Moderate</p>	<p>There are detailed infection prevention policies which have been developed with input from an infection prevention specialist. The policies cover all requirements of the standard.</p> <p>Policies include a single use items policy issued in July 2020 which states single use items are to be discarded after one use and a disinfection and sterilisation policy issued in July 2020 which states reusable items may be disinfected through thermal disinfection, or immersion in an approved</p>	<p>Single use items are not discarded after use as required by the organisation's policy and there is no clear process for the disinfection of reusable wound care instruments.</p> <p>No auditing of decontamination and disinfection of any medical instruments was occurring.</p>	<p>The service ensures staff are aware of the policy related to single use items and that there is a clear procedure for staff to follow when disinfecting reusable wound care instruments. Conduct audit of the decontamination and disinfection of any medical instruments that are used and reused for wound care.</p>

<p>(b) Aseptic technique;  (c) Transmission-based precautions;  (d) Prevention of sharps injuries;  (e) Prevention and management of communicable infectious diseases in service providers and users;  (f) Management of current and emerging multi-drug-resistant organisms;  (g) Outbreak management;  (h) Decontamination and reprocessing of reusable medical devices and equipment;  (i) Single-use items;  (j) Health care-associated infection (HAI) surveillance;  (k) The built environment.</p>		<p>chemical disinfectant. The policy notes sterilisation of equipment by the use of chemical agents is not used in the facility.</p> <p>However, staff were not familiar with the policy and do not have a procedure to guide them in the decontamination and disinfection of instruments used for wound dressings, this includes scissors, forceps and tweezers. The RN on duty was not aware of the organisation's policy and described the process for disinfection of instruments used in the facility. The process described was not in line with the organisation's policy and did not meet required infection prevention standards. Single use items were observed to be included in the disinfection process and not discarded. Instruments were stored loose in the medication trolley and not wrapped and stored appropriately once disinfected, increasing the risk of cross infection for residents.</p> <p>Audit of the decontamination of reusable medical instruments used for wound care does not occur.</p>		<p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

No data to display
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End of the report.