

# Avondale Lifecare Limited - Avondale Lifecare

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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>	Avondale Lifecare Limited
<b>Premises audited:</b>	Avondale Lifecare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 14 July 2022    End date: 15 July 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>	64

# 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 haumarua | 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
	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
	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

Avondale Lifecare provides age-related residential care services (rest home and hospital), dementia care services, respite, and long-term health – chronic health conditions care, for up to 67 residents. The facility is owned and operated by the New Zealand Aged Care Services Limited.

This certification audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family/whānau members, managers, staff, and a general practitioner.

The audit has identified that improvements are required related to completion of interRAI assessments, care planning, expiry of the building warrant of fitness, strategic planning, the quality and risk system, human resources practices, and infection control.

## 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.
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Avondale Lifecare works collaboratively to support and encourage a Māori world view of health in service delivery. There is a cultural safety policy to guide staff to ensure the needs of residents who identify as Māori are met in a manner that respects their cultural values and beliefs. Cultural and spiritual needs are identified on admission and considered in daily service delivery. Principles of mana motuhake practice were evidenced in service delivery.

Pacific peoples are provided with services that recognise their worldviews and are culturally safe.

Residents and their family/whānau are informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code). All staff receive in-service education on the Code. The provider maintains a socially inclusive and person-centred service. The residents confirmed that they are treated with dignity and respect. Consent is obtained where and when required. Residents are safe from abuse.

Residents and family/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/family and legal representatives are involved in decision making. Advance directives are followed wherever possible.

Complaints are resolved promptly and effectively in collaboration with all parties involved. There are currently two complaints received via the Health and Disability Commissioner that are in progress and yet to be resolved.

## 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 governing body assumes accountability for service delivery. This includes honouring Te Tiriti o Waitangi and reducing barriers to improve outcomes for Māori, Pasifika, and tangata whaikaha. The governing body does not yet have meaningful inclusion of Māori in the governance groups and is looking for opportunities to meet this requirement.

Planning is currently limited to a business plan which outlines the goals for Avondale Lifecare. Policies and procedures are in place.

Quality and risk management information is collected to support service delivery and care. Collection of data occurs, and this is reported numerically monthly to the clinical governance group, Adverse events are documented, and corrective actions identified. The service complies with statutory and regulatory reporting obligations.

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

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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Entry processes are efficiently managed. Qualified personnel assess residents on admission. The service works in partnership with the residents and their family/whānau to assess, plan and evaluate care. The care plans demonstrated appropriate interventions and individualised care. Residents are referred to specialist services and to other health services as required.

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

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

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

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

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.		Subsections applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. The building warrant of fitness was expired. Electrical equipment has been tested as required. External areas are accessible, safe and provide shade and seating, and meet the needs of people with disabilities.

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

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.

Some subsections applicable to this service partially attained and of low risk.

The governance group is aware of their responsibilities to the infection prevention and antimicrobial stewardship programme. Management staff at Avondale Lifecare ensure the safety of residents and staff through a planned infection prevention and antimicrobial stewardship programme that is appropriate to the size and complexity of the service. It is adequately resourced.

The implemented infection prevention (IP) programme and antimicrobial stewardship (AMS) programme is appropriate to the size and complexity of the service. A suitably qualified registered nurse leads the programme.

Specialist infection prevention advice is accessed when needed. Staff demonstrated good understanding about the principles and practice around infection prevention and control. This is guided by relevant policies and supported through education and training.

Surveillance of health care associated infections is undertaken with results shared with staff. Follow-up action is taken as and when required. There was an infection outbreak that was managed effectively since the previous audit.

## 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.

The governance group is aware of their responsibilities in relation to restraint elimination. The service is a restraint free environment, and this is supported by policies and procedures. There were no residents using restraint at the time of audit.

A comprehensive assessment, approval, monitoring process, with regular reviews is in place should this be required. Staff demonstrated a sound knowledge and understanding of the restraint process, including least restrictive practices, de-escalation techniques, and alternative interventions.

## 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	22	0	3	2	0	0
Criteria	0	142	0	6	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>Avondale Lifecare (Avondale) is currently developing policy, procedure, and processes to embed and enact Te Tiriti o Waitangi and to support equity for Māori. Residents and family/whānau interviewed reported that mana motuhake is respected, staff respected their right to self-determination, and they felt culturally safe. Interview with the organisation’s managers and governance representative confirmed that they are aware of their responsibility to support equity for Māori.</p> <p>A Māori health plan has been developed which is used for residents who identify as Māori. Residents are involved in providing input into their care planning, activities, and dietary needs. Care plans included the physical, spiritual, family/whānau, and psychological health of the residents. Māori were resident in the facility during the audit.</p> <p>The service supports increasing Māori capacity by employing more Māori staff members across differing levels of the organisation as vacancies and applications for employment permit. This has been</p>

		<p>difficult given the national health workforce shortage. Ethnicity data is gathered when staff are employed. There were staff who identified as Māori at the time of audit.</p> <p>The service has links with a Māori health support through the DHB, local Māori organisations, and mana whenua. A kaumatua is available to assist the organisation, residents, and their families/whānau as required.</p>
<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>	FA	<p>Avondale identifies and works in partnership with Pacific communities and organisations. A process to review the current Pacific plan to better support culturally safe practices for Pacific peoples using the service has been commenced. There were Pasifika residents and staff from Pacific peoples at the time of audit. Pasifika residents interviewed felt their worldview, cultural and spiritual beliefs were respected. There is support for Pasifika residents via staff who identify with differing Pacific peoples through a number of local Pasifika organisations.</p> <p>Interview with the organisation's facility manager (FM) and governance representative confirmed that they are aware of their responsibility to support equity for Pacific peoples. Pasifika staff were employed in varying roles in the organisation, including in senior roles.</p> <p>The service has Pasifika staff employed across differing levels of the organisation and plans to continue recruitment as vacancies and applications for employment permit. This remains difficult given the national health workforce shortage.</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</p>	FA	<p>Staff receive training on the Code of Health and Disability Services Consumers' Rights (the Code) as part of the orientation process and annual ongoing mandatory training. Staff understood residents' rights and gave examples of how they incorporate these in daily practice. The Code in English and Māori languages and the Nationwide Health and Disability Advocacy Service (Advocacy Service) posters are prominently displayed at the reception area and on notice boards around the facility. Residents and family/whānau confirmed being made aware of their rights and advocacy services during the</p>

<p>in a way that upholds their rights and complies with legal requirements.</p>		<p>admission process and explanation provided by staff on admission. The Code pamphlets are provided to residents/whānau as part of the admission process. The admission agreement has information on residents' rights and responsibilities. Residents and family/whānau confirmed that services were provided in a manner that complies with their rights.</p> <p>The service recognises Māori mana motuhake by involving residents, family/whānau or their representative of choice in the assessment process to determine residents' wishes and support needs.</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 experiences.</p>	<p>FA</p>	<p>Information about individual values and beliefs, culture, religion, disabilities, gender, sexual orientation, relationship status and other social identities or characteristics are sought from residents and their family/whānau on admission. These were noted in the residents' care plans sampled. Residents and family/whānau confirmed they were consulted on individual values and beliefs and staff respected these.</p> <p>The services provided demonstrated respect for residents' dignity, privacy, confidentiality, and preferred level of independence. Staff were observed respecting residents' personal areas and privacy by knocking on the doors and announcing themselves before entry. Personal cares were provided behind closed doors. Shared bathrooms and toilets had clear signage when in use.</p> <p>Residents are supported to maintain as much independence as possible, for example make their own bed and complete their personal cares if able and can freely attend to activities of choice in the community (COVID-19 restrictions permitting). Residents and family/whānau confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, independence, and choices.</p> <p>Tikanga 'flipcharts' were posted on notice boards around the facility to promote te reo Māori and tikanga. The principles of the Treaty are incorporated into daily practice. The cultural safety policy has documented Māori customs to guide on recognition of Māori values and beliefs. Interviewed staff understood the Māori cultural customs</p>

		<p>and confirmed these are observed where required, including room blessing by a kaumatua. The Māori Health Plan developed focusses on holistic health embodied in the Māori health model Te Whare Tapa Whā.</p> <p>Whānau and residents confirmed that the service responds to tāngata whaikaha needs and enable their participation in te ao Māori. The facility manager (FM) stated that additional advice can be accessed through the DHB if required.</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>Professional boundaries, misconduct, code of conduct, discrimination, and abuse and neglect information is included in the staff employment handbook. These are discussed with all staff during their orientation. There was no evidence of discrimination or abuse observed during the audit. Policies and procedures outline safeguards in place to protect residents from abuse, neglect and any form of exploitation, though these were overdue for review (refer criterion 2.2.2). In interviews, staff confirmed awareness of professional boundaries and understood the processes they would follow, should they suspect any form of exploitation.</p> <p>A residents' property list is completed, and belongings labelled on admission.</p> <p>The FM stated that any observed or reported racism, abuse or exploitation is addressed promptly. Residents expressed that they have not witnessed any abuse or neglect, they are treated fairly, they feel safe, and protected from abuse and neglect. There are systems in place to monitor the effectiveness of the processes in place to safeguard residents, such as whānau/family and residents' meetings, but these have not consistently taken place (refer criterion 2.2.1).</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>FA</p>	<p>Residents/whānau are given an opportunity to discuss any concerns they may have to make informed decisions either during admission or whenever required. This was observed on the days of the audit and confirmed in interviews with residents, family/whānau and EPOAs for residents in the dementia unit. Communications and referrals with allied health care providers was recorded in residents' records.</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>Residents and family/whānau stated they were kept well informed about any changes to their/their relative's status and were advised in a timely manner about any incidents or accidents and medical reviews. This was supported in residents' records. Staff understood the principles of effective and open communication, which is described in policies and procedures. However, the policies were last reviewed in 2017 (refer to criterion 2.2.2).</p> <p>Information provided to residents and family/whānau is mainly in the English language. However, the FM stated that information can be accessed in other languages if required. Interpreter services are engaged through the local DHB if required. Written information and verbal discussions are provided to improve communication with residents and their family/whānau. Open communication with resident and family/whānau is promoted through the open-door policy maintained by the FM and assistant manager (AM). Residents and family/whānau expressed satisfaction with communication with the managers and the clinical team and their response to requests. A record of phone or email contact with family/whānau was maintained.</p> <p>There is a diverse range of staff who speak a variety of languages, and who can be utilised where appropriate. Family/whānau may assist with interpretation where appropriate. Verbal, non-verbal, printed material or written communication methods are adopted to make communication and information easy for residents to access, understand, use, enact or follow.</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 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</p>	<p>FA</p>	<p>Staff understood the principles and practice of informed consent. General consent is obtained as part of the admission documents which the resident and/or their nominated legal representative sign on admission. Signed admission agreements were evidenced in the sampled residents' records. Informed consent for specific procedures had been gained appropriately. Consent forms for residents who were unable to consent were signed by the residents' legal representatives. Resuscitation treatment plans and advance directives were signed by residents who are competent. The general practitioner (GP) signed resuscitation treatment plans for residents who were unable to provide consent in consultation with family and EPOAs. The GP discusses the</p>

<p>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>resuscitation treatment plan with the resident, where applicable, or with the resident's family/whānau as verified in interviews with the GP, family/whānau and residents. Staff were observed to gain consent for daily cares.</p> <p>Tikanga guidelines in relation to consent is practiced. Residents confirmed that they are provided with information and are involved in making decisions about their care. Where required, a nominated support person or EPOA for residents in the dementia unit is involved. Residents are offered a support person through the advocacy services when required. During the admission process residents provide information on their representative of choice, next of kin or EPOA. These were documented in the admission records sampled. Communication records verified inclusion of support people where applicable.</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, and equitable system is in place to receive and resolve complaints that leads to improvements. This meets the requirements of the Code. The operator maintains a record of all complaints in a complaint register.</p> <p>Residents and whānau understood their right to make a complaint, knew how to do so, and understood their right to advocacy. Documentation sighted demonstrated that complaints are being managed in accordance with guidelines set by in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). Support and advocacy is available for complainants and a kaumatua is available to advocate for complaints from Māori if this should be required.</p> <p>There have been three complaints received since the previous audit. One was directly to the facility, which has been followed up with replies to the complainant and resolved. The second came through the ADHB (Health NZ, Northern Region) and the Health and Disability Commissioner (HDC); this has been responded to but remains open at the time of audit. A further complaint was received via the Ministry of Health (MoH) and HDC; this has also been responded to but</p>

		remains open at the time of audit.
<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>	PA Low	<p>The governance body for Avondale Lifecare consists of three owners/directors who oversee the services with the assistance of a clinical and operations manager who is a registered nurse (RN). Clinical governance is appropriate for the size and complexity of the service. Two of the three owners/directors have had education on Te Tiriti o Waitangi, tikanga Māori, and cultural safety.</p> <p>There is a business plan in place that outlines organisational goals for the service. One of the owners/directors interviewed described a planned strategic planning process which intends to clarify the service's commitment to improved outcomes and equity for Māori, Pacific peoples, and tāngata whaikaha. The planning process also intends to outline the organisation's purpose, mission, values, and direction, including how performance goals for the organisation will be monitored and reviewed at planned intervals.</p> <p>The facility manager (FM) is an experienced RN with a current practising certificate. The FM oversees clinical management for the service with the support of registered nurse staff. External support for te ao Māori and Pacific peoples is available from staff and through input from external Māori and Pasifika people and organisations. Health plans align with Te Whare Tapa Whā and Ola Manuia, as well as peoples from other ethnic backgrounds. The manager confirmed knowledge of the sector, regulatory and reporting requirements.</p> <p>Avondale Lifecare collects data on adverse events, complaints, internal audit activities, restraint, and clinical incidents (including infections). Data is collected with corrective actions noted in some instances, but these were not consistently signed off as completed or resolved. The corrective actions are also not identified as trends to support systems learning. Reporting to governance was via numeric data and did not include quality information in enough detail for the governance body to take responsibility for quality outcomes (refer 2.1.4).</p> <p>Participation for people receiving services and their families/whānau</p>

		<p>in the implementation, monitoring and evaluation of service delivery is limited to individual care plans. Resident meetings are not taking place on a regular basis, there has been one resident meeting in 2022 (May), and no resident or family/whānau satisfaction surveys conducted since before 2020.</p> <p>The service holds contracts with the DHB for rest home, hospital, and dementia care services, and for residents with long term care – chronic health conditions (LTC – CHC, under 65). Sixty-four (64) residents were receiving services under the contract at the time of audit, 13 rest home level care, 36 hospital level care, 13 dementia care, and two LTH – CHC (one receiving hospital level care and one receiving dementia care).</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 does not have a risk management plan in place to identify risks and manage mitigation strategies in respect of organisational risk (refer criterion 2.2.4).</p> <p>Quality data is being collected with corrective actions identified in some of the records sampled. Information arising from complaints, adverse events and infections are collected in line with the National Adverse Event Reporting Policy, with corrective actions raised in some instances and signed off appropriately. Trends are not identified for adverse events and infections, and this limits the organisation's ability to use information gained from these activities to improve service delivery. The facility does not benchmark quality data against any other facility or service.</p> <p>Internal audit activities have not been consistently conducted. Of the 37 internal audits planned for January to July 2022, only 12 were completed. Corrective actions were identified in the internal audits completed and these were addressed.</p> <p>There is little opportunity for residents and their family/whānau and staff to contribute to service delivery and to quality outcomes. Two staff meetings have been held in 2022. Information presented to the meetings related to organisational issues and did not include performance monitoring information. One resident meeting has been</p>



		<p>held in 2022. No satisfaction surveys have been completed since before 2020. This limits the opportunity for the facility to receive feedback on services (refer criterion 2.2.1).</p> <p>Policies and procedures reviewed covered all necessary aspects of the service and contractual requirements but were out-of-date and do not guide practice under the Ngā Paerewa standard (refer criterion 2.2.2). Of the 19 policies sampled during the audit, one had not been reviewed since 2014, 12 had not been reviewed since 2017 and two had not been reviewed since 2018.</p> <p>The FM understood and has complied with essential notification reporting requirements. There have been two section 31 notifications completed since the last audit relating to resident incidents.</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>FA</p>	<p>There is a documented and implemented process 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 adjusts staffing levels to meet the changing needs of residents. Care staff reported there were adequate staff to complete the work allocated to them though this had been difficult during a COVID-19 outbreak that affected residents and staff. Residents and whānau interviewed supported this. At least one staff member on duty has a current first aid certificate. Whilst there is 24/7 RN coverage in the facility, this has been reduced by one RN on the morning shift due to the difficulty recruiting nursing staff with a nationwide shortage of nurses in New Zealand. RNs interviewed reported that this had put pressure on them mitigated by the FM being an RN with a current practising certificate and through an extra experienced senior caregiver (team leader) being rostered onto the shift. Staff working in the dementia care area have completed the required education to meet contractual requirements. The reduction of staff has meant that there is less resource to complete interRAI assessments and care planning (refer criterion 3.2.1).</p> <p>There are two RNs on eight hour morning shifts supported by ten caregivers; six eight hours shifts, two six hour shift and two five hours. In the afternoon, there are two RNs on eight hour shifts supported by</p>

		<p>ten caregivers; six on eight hour shifts, two on five hour shifts, and two four hour shifts. Overnight there is one RN supported by five caregivers on eight hour shifts. Cleaning, laundry, and food services are carried out by dedicated support staff seven days per week. Four weeks of roster were reviewed; there were no shifts that were not covered (not including the one RN previously noted) and, while staff were working extra shifts or extra hours, there were no staff working excessive hours. Recreational activities are provided by an activities coordinator who works Monday to Friday. The facility is currently looking to recruit a diversional therapist.</p> <p>Position descriptions reflected the role of the position and expected behaviours and values. Descriptions of roles cover responsibilities and additional functions, such as holding a restraint or infection prevention and control portfolio.</p> <p>Continuing education is planned on an annual basis but not all education requirements have been completed (refer criterion 2.2.7). Competencies for medication, manual handling, fire and emergency management (including fire drills), first aid, chemical safety, food handling, and pandemic planning (including the use of personal protective equipment (PPE)) have been completed for all relevant staff.</p> <p>Staff reported feeling well supported and safe in the workplace. There are policies and procedures in place around wellness, bullying, and harassment, though these have not been reviewed since 2017 (refer criterion 2.2.2).</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</p>	<p>PA Low</p>	<p>Human resources management policies and procedures are in place, and these are based on good employment practice and relevant legislation. However, policies and procedures have not been reviewed since 2017 (refer criterion 2.2.2).</p> <p>Ethnicity data is recorded and used in line with health information standards. A sample of staff records reviewed showed that the organisation's policies are not being consistently implemented in relation to reference checking, orientation, and performance appraisal.</p>

<p>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>Eight personnel files were reviewed. Of these, reference checking had not been completed for three out of five staff recruited in the 2021-2022 period, two of the five staff employed over the 2021-2022 period have not had orientation documented, and two staff from the five that were eligible (started over 12 months ago) had not had a performance appraisal since 2020.</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>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. The clinical notes were current, integrated, and legible and met current documentation standards. No personal or private resident information was on public display during the audit. Archived records are held securely on site and are clearly labelled for ease of retrieval. Residents' information is held for the required period before being destroyed.</p> <p>Avondale Lifecare uses a paper-based information management system for clinical files and uses the electronic system for medication management and interRAI assessment. InterRAI assessment information is entered into the Momentum electronic database and reports are printed and kept in individual residents' files. Staff have individual passwords to access the electronic systems.</p> <p>The service provider is not responsible for National Health Index registration.</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</p>	<p>FA</p>	<p>The entry criteria are clearly communicated to people, family/whānau, and where appropriate, to local communities and referral agencies, verbally on enquiry and in online platforms. Enquiries are managed by the FM, assistant manager (AM), and the administrator. Information about the services provided can be explained and discussed with the enquirer as required. Residents enter the service when their required level of care has been assessed and confirmed by the local needs' assessment and coordination service (NASC). EPOAs have consented to admission and specialist referrals for residents in the dementia unit.</p> <p>The AM reported that the rights and identity of the residents are</p>

<p>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>		<p>protected by ensuring residents' information is kept confidential. Family/whānau were updated where there was delay to entry to service. This was verified in enquiry records sampled.</p> <p>The AM reported that if a referral is received and the prospective resident does not meet the entry criteria or there is no vacancy, entry to services is declined. The resident and family/whānau are informed of the reason for the decline and of other options or alternative services if required. The service maintains a record of the enquiries and the declined entry. However, routine analysis to show entry and decline rates that include specific data for entry and decline rates for Māori is still to be implemented.</p> <p>The service has developed meaningful partnerships with Māori communities and organisations to benefit Māori individuals and whānau. The GP stated that Māori health practitioners or traditional Māori healers will be consulted if required.</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 RNs are responsible for completing nursing admission assessments, care planning and evaluation. The initial nursing assessments sampled were developed within 24 hours of an admission in consultation with the residents and family/whānau where appropriate. Initial care plans were developed within 24-48 hours of an admission. The service uses assessment tools that include consideration of residents' lived experiences, oral health, cultural needs, values, and beliefs. Cultural assessments were completed by staff who have completed appropriate cultural training. There were five trained interRAI assessors. However, in three out of eight files sampled for review initial interRAI assessments were not completed and in another three files routine six-monthly interRAI reassessments were overdue. A total of 48 interRAI reassessments were overdue for routine assessment.</p> <p>The care plans sampled reflected identified residents' strengths, goals and aspirations aligned with their values and beliefs documented. However, three out of eight sampled files for review did not have long term care plans completed. Detailed strategies to maintain and promote the residents' independence, wellbeing, and where</p>

		<p>appropriate early warning signs and risks that may affect a resident's wellbeing were documented. Behaviour management plans were completed for any identified behaviours of concern. Management of specific medical conditions was well documented with evidence of systematic monitoring and regular evaluation of responses to planned care. Any family/whānau goals and aspirations identified were addressed in the care plans.</p> <p>Cultural guidelines were used to complete Māori health and wellbeing assessments to ensure that tikanga and kaupapa Māori perspectives permeate the assessment process. The assessment process supports residents who identify as Māori and whānau to identify their own pae ora outcomes in their care plan. The staff confirmed they understood the process to support residents and whānau. Residents' family/whānau for residents who identify as Māori confirmed satisfaction with the services being provided. The service is actively working towards updating the organisational plans to reflect equity in service provision (refer criterion 2.2.8).</p> <p>The service has a contracted GP who provides medical services. Medical assessments were completed by the GP within two to five working days of an admission. Routine medical reviews were completed three monthly for rest home level residents and monthly for hospital level and dementia levels residents. More frequent reviews were completed as determined by the resident's condition where required. Medical records were evidenced in sampled records.</p> <p>The care plans evidenced service integration with other health providers including activity notes, medical and allied health professionals. Notations were clearly written, informative and relevant. Any changes in residents' health were escalated to the GP. Records of referrals made to the GP when a resident's needs changed, and timely referrals to relevant specialist services as indicated were evidenced in the residents' files sampled. In interview, the GP confirmed they were contacted in a timely manner when required, that medical orders were followed, and care was implemented promptly. Short-term care plans were completed for any events and identified</p>
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		<p>acute resident care needs.</p> <p>Residents' records, observations, and interviews verified that care provided to residents was consistent with their assessed needs, goals, and aspirations. A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs. The residents and family/whānau interviewed confirmed their involvement in evaluation of progress and any resulting changes.</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>The activities coordinator (AC) provides the activities programme. The weekly activities programme is posted on notice boards around the facility. The AC reminds and invites residents each day to activities on schedule. The AC is in the process of completing dementia specific training. The service is working towards recruiting a diversional therapist to support the AC.</p> <p>Residents' activity needs, interests, abilities, and social requirements are assessed on admission using a social history assessment form that is completed with input from residents and family/whānau. The activities programme is regularly reviewed through the six-monthly activity plan reviews to help formulate an activities programme that is meaningful to residents. Resident's activity needs are evaluated six monthly and when there is a significant change in the resident's ability. This was evident in the records sampled.</p> <p>Individual, group activities and regular events are offered. Activities on the programme reflected residents' goals, ordinary patterns of life and included normal community activities. Residents are supported to access community events and activities where possible. Community activities have been limited due to COVID-19 pandemic restrictions. Residents are supported to attend external church services and visit family in the community where appropriate. The activities on the programme include exercises, van trips, puzzles, walks, Māori and Pacific music external entertainers, birthday celebrations, knitting and craft. Monthly themes and international days are celebrated. Cultural events celebrated include Waitangi, Matariki and St Patrick's day celebrations. The AC reported that community initiatives that meet the</p>

		<p>health needs and aspirations of Māori and whanau will be resumed such as kapa haka community group entertainers when visiting restrictions are lifted. Māori music is played during music sessions. Daily activities attendance records were maintained. Facility owned pets were on site. Residents are supported to attend to gardening activities if desired.</p> <p>Activities for residents in the dementia unit include walks in the secure garden, colouring, puzzles, quiz, music and one-on-one chats. Residents were observed participating in a variety of activities on the days of the audit. 24-hour activity plans were completed for residents in the dementia unit. Residents can freely access the secure gardens. This was observed on the days of the audit. Interviewed residents and family/whānau confirmed they find the programme satisfactory.</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 and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The implemented medicine management system is appropriate for the scope and size of the service. The medication management policy identified all aspects of medicine management in line with current legislative requirements and safe practice guidelines.</p> <p>The service uses an electronic medication management system. The RNs were observed administering medicines correctly. They demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage and had a current medication administration competency.</p> <p>Medicines were prescribed by the GP. The prescribing practices included the prescriber's name and date recorded on the commencement and discontinuation of medicines and all requirements for 'as required' (PRN) medicines. Medicine allergies and sensitivities were documented on the resident's chart where applicable. The three-monthly medication reviews were consistently recorded on the medicine charts sampled. The GP stated that over-the-counter medication and supplements are considered as part of the person's medications where requested. Standing orders are not used.</p>

		<p>The service uses pre-packaged medication packs. The medication and associated documentation were stored safely. Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Clinical pharmacist input was provided six monthly and on request. Unwanted medicines are returned to the pharmacy in a timely manner. The records of temperatures for the medicine fridge and the medication room sampled were within the recommended range. Residents and their family/whānau, are supported to understand their medications when required. The GP and RN reported that when requested by Māori, appropriate support and advice is provided.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner when required. There is an implemented process for comprehensive analysis of medication errors and corrective actions implemented as required. Medication audits were completed with corrective action plans implemented as required.</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>FA</p>	<p>Residents' nutritional requirements are assessed on admission to the service in consultation with the residents and family/whānau. The nutritional assessments identify residents' personal food preferences, allergies, intolerances, any special diets, cultural preferences, and modified texture requirements. A nutritional requirement form is completed and shared with the kitchen staff and any requirements are accommodated in daily meal plans. Copies of individual food preferences were available in the kitchen folder.</p> <p>The food is prepared on site by a chef and two cooks and is in line with recognised nutritional guidelines for older people. Kitchen staff have received required food safety training. The menu follows summer and winter patterns in a four weekly cycle and was reviewed by a qualified dietitian on 31 March 2022. The food is served through the kitchen server to the residents in two dining rooms for dementia and rest home level residents. The food is transported in a baine marie to the hospital unit dining room. Residents who chose not to go</p>



		<p>to the dining room for meals had meals delivered to their rooms.</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 Ministry for Primary Industries. The current food verification audit was completed on 26 May 2022. Food temperatures were monitored appropriately and recorded as part of the plan. On the days of the audit, the kitchen was clean and kitchen staff were observed following appropriate infection prevention measures during food preparation and serving.</p> <p>Residents' weight is monitored monthly by the clinical staff and there was evidence that any concerns in weight identified were managed appropriately with referral made to the dietitian for weight loss issues. Additional supplements were provided where required. The cook reported that menu options for residents who identify as Māori and other cultures will be offered when requested. The menu includes culturally specific food like Indian curry, roti, rice and Māori specific vegetables. Whānau/family are welcome to bring culturally specific food for their relatives. The resident who identifies as Māori expressed no concerns with the meals provided.</p> <p>Mealtimes were observed during the audit. Residents received the support they needed and were given enough time to eat their meal in an unhurried fashion. Confirmation of residents' satisfaction with meals was verified by residents, and in resident meeting minutes (refer criterion 2.2.1).</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,</p>	FA	<p>There is a transfer, exit or discharge policy to guide staff on transfer, exit and discharge processes. Transfers and discharges are managed by the RNs in consultation with the resident, their family/whānau and the GP. A transfer form is completed when transferring residents to acute services. The service coordinates with the receiving service over the phone to provide verbal handover for safe and timely transfer or discharge process. The RN reported that an escort is provided for transfers when required. Residents are transferred to the accident and emergency department in an ambulance for acute or emergency</p>

<p>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>		<p>situations. This was evidenced during the audit days. The resident's EPOA was advised of the transfer. Transfer documentation in the sampled records evidenced that appropriate documentation and relevant clinical and medical notes were provided to ensure continuity of care. The reason for transfer was documented on the transfer letter and progress notes.</p> <p>Records sampled evidenced that the transfer and discharge planning included risk mitigation and current needs of the resident. The discharge plans sampled confirmed that where required, a referral to other allied health providers to ensure safety of the resident was completed. Upon discharge, any resident's paper-based information is collated, and archived in a secure area and the resident is discharged from the electronic systems.</p> <p>The RN reported that referral or support to access kaupapa Māori agencies where indicated, or requested, will be offered. The service has links with a local kaumatua. Referrals to seek specialist input for non-urgent services are completed by the GP or RN. Examples of referrals completed were in residents' files sampled, including to the eye specialists, wound nurse specialist and mental health team. Residents, family/whanau and EPOAs were kept informed of the referral process, reason for transfer or discharge as confirmed by documentation and interviews.</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> <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</p>	<p>FA</p>	<p>Appropriate systems are in place to ensure the residents' physical environment and facilities (internal and external) are fit for their purpose, well maintained and that they meet legislative requirements. However, the building has a building warrant of fitness which expired on 22 June 2022. The planned maintenance schedule includes electrical testing and tagging, resident equipment checks, and calibrations of weighing scales and clinical equipment. Monthly hot water tests are completed for resident areas and were below 45 degrees Celsius. There are environmental and building compliance audits, completed as part of the internal audit schedule. There are currently no plans for further building projects requiring consultation, but the manager is aware of the requirement to consult for any</p>

<p>belonging, independence, interaction, and function.</p>		<p>changes/development in the future.</p> <p>The environment was comfortable and accessible, promoting independence and safe mobility. Personalised equipment was available for residents with disabilities to meet their needs. Spaces were culturally inclusive and suited the needs of the resident group. There are shared dining room and lounge facilities. Lounge areas are used for activities for residents. Outdoor areas are planted and landscaped with appropriate seating and shade. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Some rooms have ensuite bathroom facilities.</p> <p>Residents' rooms are personalised according to their preference. All rooms have external windows which can be opened for ventilation; safety catches are in place. Corridors are wide and promote safe mobility with the use of mobility aids and handrails, residents were observed moving freely around the areas with mobility aids during the audit.</p> <p>Residents and family/whānau were happy with the environment, including heating and ventilation, privacy, and maintenance. Care staff interviewed stated they have adequate equipment to safely deliver care for residents.</p>
<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>	<p>FA</p>	<p>Fire, civil defence, and pandemic plans and policies direct the facility in their preparation for emergency challenges. These described the procedures to be followed as well as the duties required by staff (e.g., as fire wardens). Staff have been trained and those interviewed knew what to do in an emergency. The fire evacuation plan was approved by the New Zealand Fire Service on 15 October 2014. A fire evacuation drill was last held on 23 February 2022. Adequate supplies for use in the event of a civil defence emergency meet The National Emergency Management Agency recommendations for the region. In the event of a power outage cooking facilities are available. The facility has a contract for the provision of a generator following any civil defence emergency. Emergency management is included in staff orientation and as part of the ongoing education plan. A minimum of</p>

		<p>one person trained in first aid is always available on site.</p> <p>Call bells alert staff to residents requiring assistance, these are present in all rooms, bathrooms, and communal facilities. Call bells are checked as part of the internal audit programme. Residents and family/whānau reported staff respond promptly to call bells.</p> <p>Security arrangements are in place, the building is secure at all times. Information about security and emergency procedures is given to residents and their family/whānau on admission to the facility.</p> <p>Visiting is by appointment under the COVID-19 orange setting. Precautions are being taken with rapid antigen testing (RAT) prior to entry to the facility.</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>	<p>FA</p>	<p>The governance body is aware of their responsibilities in relation to infection control and antimicrobial stewardship (AMS) and it is appropriate to the size and complexity of the service. Data on infection rates and antibiotic usage, issues and significant events are reported to the board through the clinical governance pathway. There is access to specialist support through the DHB (Health NZ). There is a stepwise approach to infection prevention and control.</p> <p>Cultural advice is accessed where appropriate. Staff were familiar with policies and were observed to follow these correctly. Residents and their family/whānau are educated about infection prevention in a manner that meets their needs.</p> <p>A pandemic/infectious diseases response plan is documented and has been regularly tested. 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</p>	<p>PA Low</p>	<p>There is a nominated infection control nurse who oversees and coordinates the implementation of the IPC programme with the support of the AM. The infection control nurse's role, responsibilities and reporting requirements are defined in the infection control nurse's job description. The infection control nurse has completed education</p>

<p>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>on infection prevention and control. They have access to shared clinical records and diagnostic results of residents. There was no evidence of the annual review of the IP programme.</p> <p>There is a pandemic and infectious disease outbreak management plan in place that is reviewed at regular intervals. There were sufficient IP resources including personal protective equipment (PPE). The IP resources were readily accessible to support the pandemic response plan if required.</p> <p>The clinical governance team has input into other related clinical policies that impact on health care associated infection (HAI) risk. Staff have received education in IP at orientation and through ongoing annual education sessions. The FM and the infection control nurses provide education. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. Additional staff education has been provided in response to the COVID-19 pandemic. Education with residents was on an individual basis and as a group in residents' meetings. This included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. This was confirmed in the records sampled.</p> <p>The infection control nurses liaise with the FM on PPE requirements and procurement of the required equipment, devices, and consumables through approved suppliers and the DHB. The FM stated that they will be involved in the consultation process for any proposed design of any new building or when significant changes are proposed to the existing facility. Currently there are no proposed changes.</p> <p>Medical reusable devices and shared equipment are appropriately decontaminated, sterilised or disinfected based on recommendation from the manufacturer and best practice guidelines. Single-use medical devices are not reused. There is a decontamination, sterilisation, and disinfection policy to guide staff. Regular infection control audits were completed, and where required, corrective actions</p>
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		<p>were implemented.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following appropriate infection control practices, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility.</p> <p>The cultural safety policy includes culturally safe practices in infection prevention and control. The FM reported that residents who identify as Māori will be consulted on IP requirements as needed with the support of the kaumatua if required, to acknowledge the spirit of Te Tiriti. In interviews, staff understood these requirements. The FM stated that educational resources in te reo Māori will be provided when required. Samples of educational resources in te reo Māori were sighted.</p>
<p>Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation</p> <p>The people: I trust that my service provider is committed to 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>	FA	<p>The AMS programme was developed using evidence-based antimicrobial prescribing guidance and expertise. The programme is appropriate for the size, scope and complexity of the service. The service has an antibiotic prescribing policy to guide the use of antimicrobials. The policy in use aims to promote optimal management of antimicrobials to maximise the effectiveness of treatment and minimise potential for harm (including drug resistance and toxicity). The policy was last reviewed in April 2017 (refer to criterion 2.2.2).</p> <p>Responsible use of antimicrobials is promoted. Monthly records for infections including evidence of monitoring the quality and quantity of antimicrobial prescribing, dispensing, and administration and occurrence of adverse effects were maintained.</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>	FA	<p>The infection surveillance programme is appropriate for the size and complexity of the service. Infection data is collected, monitored and reviewed monthly. The data is collated, and action plans are implemented. The HAIs being monitored include infections of the urinary tract, skin, eyes, respiratory and wounds. Surveillance tools are used to collect infection data and standardised surveillance</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>		<p>definitions are used.</p> <p>Surveillance records did not include ethnicity data.</p> <p>Infection prevention audits were completed including cleaning, laundry, and hand hygiene. Relevant corrective actions were implemented where required.</p> <p>Infection statistics quarterly report was posted on the notice board in the communication room. However, minutes of staff meetings do not demonstrate that infection statistics are consistently communicated with staff (refer criterion 2.2.1). Records of monthly data sighted confirmed minimal numbers of infections, comparison with the previous month, reason for increase or decrease and action advised. Any new infections are discussed at shift handovers for early interventions to be implemented.</p> <p>Residents were advised of any infections identified and family/whānau where required. This was confirmed in progress notes sampled and verified in interviews with residents and family/whānau. There was an infection outbreak reported in March 2022 which was managed effectively with appropriate notification completed.</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>	<p>FA</p>	<p>A clean and hygienic environment supports prevention of infection and transmission of anti-microbial resistant organisms. Staff follow documented policies and processes for the management of waste and infectious and hazardous substances. Laundry and cleaning processes are monitored for effectiveness. Staff involved have completed relevant training and were observed to carry out duties safely. Chemicals were stored safely in a locked storage room.</p> <p>There are regular internal audits of the cleaning and laundry services, in addition to the quarterly reporting and monitoring of infection rates and antibiotic use. Adequate PPE supplies were available in the laundry and cleaning cupboard. Residents and family/whānau reported that the laundry is managed well, and the facility is kept clean and tidy. This was confirmed through observations.</p>

<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>	<p>FA</p>	<p>Avondale Lifecare is a restraint free environment. Restraint has not been used in the facility since 2014. The FM described the focus on maintaining a restraint-free environment. Restraint was understood by the staff interviewed who also described their commitment to maintaining a restraint free environment and therefore upholding the 'mana' of the residents under their care.</p> <p>Policies and procedures meet the requirements of the standard though these are overdue for review (refer criterion 2.2.2). The restraint coordinator (RC) is a defined role undertaken by the RN who would provide support and oversight should restraint be required in the future. There is a job description that outlines the role. The education programme includes least restrictive practices, safe restraint practice (including monitoring), alternative cultural-specific interventions, and de-escalation techniques as part of the ongoing education programme. Restraint protocols are covered in the orientation programme.</p> <p>The RC, in consultation with the facility's GPs, would be responsible for the approval of the use of restraints should this be required in the future and there are clear lines of accountability. Additionally, input from the facility's cultural advisors is available as required. For any decision to use or not use restraint, there is a process to involve the resident, their EPOA and/or family/whānau as part of the decision-making process. There is a process in place to report restraint to clinical governance if it should be used in the future.</p> <p>The RC continues to maintain a restraint register and this includes enough information to provide an auditable record should restraint be again used. The RC also undertakes a six-monthly review of all residents who may be at risk and outlines the strategies to be used to prevent restraint being required. GPs are involved in the review and the outcome of the review is reported to the FM and to the clinical governance of the organisation. Any changes to policies, guidelines, education, and processes are implemented if indicated.</p>
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## 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 2.1.2</p> <p>Governance bodies shall ensure service providers' structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.</p>	PA Low	<p>There is no plan in place to identify, monitor, review and evaluate the organisation's structure, purpose, values, scope, direction, performance, and goals. The owner/director interviewed reported that a strategic planning process is planned to take place. The intention is that, once this process is completed, it will outline the structure, purpose, values, scope, direction, performance, and goals of the organisation.</p>	<p>There is no plan in place to make sure that the organisation's' structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.</p>	<p>Strategic planning, when completed, will outline the organisation's structure, purpose, values, scope, direction, performance, and goals and ensure these are clearly identified, monitored, reviewed, and evaluated at defined intervals.</p> <p>180 days</p>
<p>Criterion 2.2.1</p> <p>Service providers shall ensure the quality and risk management system has executive commitment and</p>	PA Low	<p>Participation by residents and staff is not taking place consistently. There have been two staff meetings and one resident meeting in 2022, and no satisfaction surveys have been</p>	<p>Participation by residents and staff is not consistently taking place. There have been no satisfaction surveys conducted since before 2020.</p>	<p>Ensure residents and staff can consistently participate in quality management activities to improve services within the organisation.</p>

demonstrates participation by the workforce and people using the service.		conducted since before 2020. Quality information is not being shared at staff meetings or dispersed when meetings are cancelled to promote improvement within the organisation. Input from residents was evident in the minutes from the one meeting that had taken place. Information was sought around activities, food, and service delivery.		180 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	The quality management framework does include collection of risk management data around adverse events and infections but does not include trend analysis of these. This means that it is difficult for the organisation to assess and address risk and to monitor opportunities for service improvement. The lack of a risk management plan means that risk is not identified and mitigated. Many of the policies and procedures sighted have not been reviewed and are no longer fit for purpose (some not since 2014, 2017 or 2018).	Risk, through adverse event and quality indicator analysis, does not link to a risk system to improve organisational practices. Risks to the organisation are not identified and mitigated. Most of the policies and procedures are out-of-date and not fit for purpose.	<p>Adverse events and quality indicators need to be analysed and trended for opportunities to improve service and to inform corrective action, and these need to link to a quality and risk management system and a risk management plan. Policies and procedures are reviewed to ensure they are fit for purpose.</p> <p>90 days</p>
<p>Criterion 2.2.3</p> <p>Service providers shall evaluate progress against quality outcomes.</p>	PA Moderate	Quality information is collected but is not analysed through trend analysis to evaluate progress across quality outcomes. Out of 37 internal audits scheduled for January-July 2022, only 12 were completed. Of the audits completed, corrective actions were identified and resolved/signed off appropriately.	There is no trend analysis of quality data collected and data collection is not utilised to evaluate quality improvement progress. Internal audits are not consistently conducted as scheduled.	Data is collected and analysed with trends identified to evaluate progress across quality outcomes. Internal audits are completed as scheduled. Information gained from quality information collection is utilised to support quality improvement.

				90 days
<p>Criterion 2.4.1</p> <p>Service providers shall develop and implement policies and procedures in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Policies and procedures are in place (overdue for review) in relation to recruitment and this includes the requirement to reference check. Interviews were sighted in all files reviewed. Visas, where applicable, were current. Police vetting and COVID-19 vaccination checks were completed. Professional qualifications were checked for authenticity and currency. Reference checks have not been completed for three out of five staff recruited in the 2021-2022 period, orientation and performance appraisal has not been consistently completed (refer criteria 2.4.4 and 2.4.5).</p>	<p>Policies and procedures are overdue for review, references have not been collected for three out of five staff recruited in the 2021-2022 period.</p>	<p>A process is put into place to ensure that policies and procedures are reviewed in a timely manner and that all staff are reference checked prior to commencing employment, in line with the organisation's policy and procedure requirements.</p> <p>180 days</p>
<p>Criterion 2.4.4</p> <p>Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided.</p>	PA Low	<p>Eight files were examined. Two of the five staff employed over the 2021-2022 period have not had orientation documented.</p>	<p>Orientation is not being consistently completed and documented for all staff.</p>	<p>A process is put into place to make sure all staff have orientation completed and documented on commencing employment, in line with the organisation's policy and procedure requirements.</p> <p>180 days</p>
<p>Criterion 2.4.5</p> <p>Health care and support workers shall have the opportunity to discuss and</p>	PA Low	<p>Eight files were examined. Two staff have not had a performance appraisal since 2020.</p>	<p>Staff do not consistently have the opportunity to discuss their performance.</p>	<p>A process is put into place to ensure all staff have the opportunity to discuss their performance, in line with the</p>

review performance at defined intervals.				organisation's policy and procedure requirements.  180 days
<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>	PA Moderate	<p>A range of clinical assessments, including interRAI, referral information, and the NASC assessments served as a basis for care planning. Residents' and family/whānau/ EPOA for residents in the dementia unit, were involved in the assessment and care planning processes. Relevant outcome scores have supported care plan goals and interventions. Residents and family/whānau confirmed their involvement in the assessment and care planning process. Some interRAI assessments and long-term care plans were not completed within three weeks of an admission. These residents' care was provided as per initial care plans completed and was reported by residents and family/ whānau to be adequate to address the residents' needs. There is potential risk of residents not receiving adequate support as changes may not be captured in a timely manner when timely assessments are not completed. There has been a reduction in RN coverage to one RN per shift resulting in interRAI assessments not being completed in a timely manner.</p>	<p>Three out of eight residents' files sampled for review did not have initial interRAI assessments and long-term care plans completed within three weeks of admission.</p> <p>In three out of eight files sampled for review routine six-monthly interRAI reassessments were overdue.</p> <p>The interRAI assessment summary report evidenced that 48 routine six-monthly interRAI reassessments were overdue with an interval of between 31 days to 152 days.</p>	<p>Ensure interRAI assessments are completed in a timely manner as per contractual requirements.</p> <p>90 days</p>

<p>Criterion 3.2.5</p> <p>Planned review of a person's care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;</p> <p>(b) Include the use of a range of outcome measurements;</p> <p>(c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations;</p> <p>(d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented;</p> <p>(e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.</p>	<p>PA Moderate</p>	<p>Residents' care was evaluated on each shift in the progress notes by the healthcare assistants. Any changes noted were reported to the RNs, as confirmed in interviews and verified in the records sampled. Short term care plans were reviewed weekly or earlier if clinically indicated. Routine long-term care plan evaluations are completed following six-monthly interRAI reassessments. However, some routine long-term care plans in the reviewed files were overdue for review.</p> <p>Where evaluations were completed in a timely manner, the evaluations included the degree of progress towards the resident meeting their goals and aspirations, as well as family/whānau goals and aspirations. Where progress was different from expected, the service, in collaboration with the resident, family/whānau or EPOA, responded by initiating changes to the care plan. Residents, family/whānau and EPOAs expressed satisfaction with the level of involvement in planning care.</p>	<p>Three out of eight residents' files sampled for review did not have routine six-monthly care plan evaluation completed.</p>	<p>Ensure long term care plans are reviewed in the timeframes required by the aged related residential care contract.</p> <p>90 days</p>
<p>Criterion 5.2.2</p>	<p>PA Low</p>	<p>The service has a clearly defined and</p>	<p>There was no evidence of</p>	<p>Ensure that the IP programme is</p>

<p>Service providers shall have a clearly defined and documented IP programme that shall be:</p> <ul style="list-style-type: none"> <li>(a) Developed by those with IP expertise;</li> <li>(b) Approved by the governance body;</li> <li>(c) Linked to the quality improvement programme; and</li> <li>(d) Reviewed and reported on annually.</li> </ul>		<p>documented IP programme implemented that was developed with input from external IP services. The IP programme was approved by the governance body and is linked to the quality improvement programme. The IP policies were developed by suitably qualified personnel and comply with relevant legislation and accepted best practice. The IP policies reflect the requirements of the infection prevention and control standards and include appropriate referencing. However, the policies were last reviewed in 2017 (refer to criterion 2.2.2). The staff understood the implemented infection prevention and control policies and procedures.</p>	<p>annual review of the IP programme.</p>	<p>reviewed annually to meet the standard requirement.</p> <p>180 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.

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End of the report.