

# Phantom 2021 Limited - Ashlea Grove Rest Home

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## Introduction

This report records the results of a Partial Provisional Audit; 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 BSI Group New Zealand Ltd, 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:

**Legal entity:** Phantom 2021 Limited

**Premises audited:** Ashlea Grove Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 4 October 2022 End date: 5 October 2022

**Proposed changes to current services (if any):** The service plans to increase dementia beds from 17 to 25 and reduce rest home beds from 20 to 10. The total number of beds will be 35 as the two current double rooms will be used for single occupancy. The reconfiguration includes building an outdoor area and office.

**Total beds occupied across all premises included in the audit on the first day of the audit: 29**



# 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
	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

Ashlea Grove Rest Home is a family-owned facility and is certified to provide rest home and dementia level care for up to 37 residents. On the day of audit there were 22 residents.

This certification audit was conducted against the Ngā Paerewa Health and Disability Services Standard and the contract with Te Whatu Ora Southern. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, GP, staff, and management.

A concurrent partial provisional audit was performed to verify the preparedness for a reconfiguration request made in June 2022. This includes: an increase of 8 dementia beds from 17 to 25; downsizing of the rest home unit from 20 to 10 beds; building of a new outside area; extra day room; and a new office. Bed numbers will reduce to 35 as all rooms will be single. The reconfiguration is planned to occur early in 2023. The audit identified the planned changes, staff roster, equipment requirements, established systems and processes are appropriate for the reconfiguration which will require verification prior to occupancy.

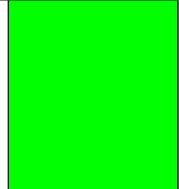
Ashlea Grove is owned and managed by two managers (husband and wife) who have owned the facility since 1 December 2021. Prior to this they have managed the facility since 2015. They are responsible for the non-clinical management of the daily operations, as well as finance and maintenance. They are supported by two registered nurses who both work part time covering Monday to Friday, (one of whom is available for clinical advice after hours), and a team of experienced staff.

Ashlea Grove have established quality and risk systems in place which are implemented. Residents and family members interviewed are complimentary of the services provided. Policies have recently been purchased from an external contractor to align with the Ngā Paerewa Health and Disability Standard.

The partial provisional audit identified shortfalls around completed refurbishments and securing the unit.

This certification audit identified shortfalls around care plan evaluations, restraint monitoring and evaluations.

## 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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There is a Māori and Pacific health plan and ethnicity awareness policy with a stated commitment to providing culturally appropriate and safe services. Staff are employed, where able, to represent the ethnicity of the group of residents. The service is working towards developing Pacific policies and a Pacific health plan in partnership with local Pasifika communities or groups.

Residents and families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumer Rights’ (the Code), and these are respected. The service works collaboratively to support and encourage a Māori world view of health in service delivery. Māori are provided with equitable and effective services based on Te Tiriti o Waitangi and principles of mana motuhake.

Services provided support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner. There was no evidence of abuse, neglect, or discrimination.

Open communication between staff, residents, and families is promoted and was confirmed to be effective. Whānau and legal representatives are involved in decision-making that complies with the law. Advance directives are followed wherever possible. The

residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The service works with other community health agencies.

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

## Hunga mahi me te hanganga | Workforce and structure

Includes 5 subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Subsections applicable to this service fully attained.
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The owners/management team assumes accountability for delivering a high-quality service. The owner/directors are actively involved with services provided.

The purpose, values, direction, scope, and goals for Ashlea Grove Rest Home have been documented. Performance is monitored and reviewed at planned intervals via the quality and risk programme and management team meetings.

The quality and risk management systems are focused on improving service delivery and care. Residents and family/whānau are given the opportunity to provide regular feedback and staff are involved in quality activities. An integrated approach includes collection and analysis of quality improvement data, identifies trends, and leads to improvements. 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 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 equitable service delivery.

The current roster provides adequate staff to cover the initial reconfiguration of the increase in dementia level beds. There is provision to employ another activities coordinator if the need arises once full occupancy is achieved.

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 low risk.
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The manager and registered nurses are responsible for the entry processes. Residents are assessed at admission by registered nurses and the general practitioner. The service works in partnership with the residents, their family/whānau or enduring power of attorneys to assess, plan and evaluate care. Residents are reviewed regularly and referred to specialist services and to other health services as required. Transfers and discharges are managed in a safe manner.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. There were adequate resources to undertake activities in the reconfigured dementia unit.

Medicines are safely stored and administered by staff who are competent to do so. Medicine for the reconfigured dementia unit will be stored safely in the nurses' station.

There is an approved food control plan, and the food service meets the nutritional needs of the residents with special needs catered for. The reconfigured dementia unit has its own dining room with adequate space to accommodate the residents. Residents verified satisfaction with meals.

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

Includes 5 subsections that support an outcome where people receive quality services through effective governance and a supported workforce.

Subsections applicable to this service fully attained.

Resident areas are personalised and reflect cultural preferences. External areas are safe and well maintained with shade and seating available. Fixtures, fittings, and flooring are appropriate, and toilets and shower facilities are constructed for ease of cleaning and conveniently located.

Testing, tagging, and calibration is completed as required. There is a current building warrant of fitness.

Fire and emergency procedures are documented. Trial evacuations are conducted. Emergency supplies are available. All staff are trained in the management of emergencies. There is a call bell system responded to in a timely manner. Security is maintained.

Partial Provisional:

A door will be changed to close off the proposed rest home area, this will provide a large dementia unit with wide corridors, and large resident rooms. The proposed dementia unit will be secure, and a new decked area is planned to provide a second outdoor area for the unit.

A ramp will be built to provide access to the rest home area. Another existing door will be utilised to provide two entrances to the rest home area. Building work and extending of the dementia unit is yet to be started.

## 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.

Subsections applicable to this service fully attained.

The implemented infection prevention and antimicrobial stewardship programme is appropriate to the size and complexity of the service. A registered nurse who has completed infection prevention and control training 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 regular education. Surveillance of health care associated infections is undertaken, and results shared with staff. Follow-up action is taken as and when required. There have been two Covid-19 infection outbreaks reported that were managed effectively.

There are processes in place for the management of waste and hazardous substances. There is adequate stock of personal protective equipment which staff have access to. Cleaning and laundry processes are sufficient to cover the size and scope of the service.

## 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.		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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The restraint coordinator is a registered nurse and provides education to the staff as part of the training plan. Ashlea Grove is committed to minimising the use of restraint. There was one resident (dementia level) using restraint regularly as a safety measure. The monitoring of this resident did not meet the requirements of the services' policy for monitoring.

Staff interviewed demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques and alternative interventions to prevent the use of restraint. Restraint usage is reviewed at meetings and during GP reviews.

## 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	26	0	2	1	0	0
Criteria	0	157	0	4	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 Health plan and ethnicity awareness policy in place which guides staff around the provision of culturally safe services for Māori resident. The policy and guidelines are based on Te Tiriti o Waitangi with the documents providing a framework for the delivery of care. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in Māori and English.</p> <p>The service has residents who identify as Māori.</p> <p>One resident file reviewed of a resident that identified as Māori had a cultural assessment that includes identification of iwi, and a Māori health care plan. The Māori health care plan identifies specific cultural interventions around food, cares, and practices as per policy and tikanga guidelines. Māori residents interviewed stated that their cultural needs are being met, and the service supports them to link with family. Residents and family/whānau are involved in providing input into the resident's care plan, activities, and their dietary needs. Interviews with the owner/director, facility manager,</p>

		<p>and staff (four caregivers, two registered nurses, one activities coordinator, one cook, one cleaner, and one laundry assistant) described cultural support with a Māori-centred approach documented and provided.</p> <p>The service employs Māori staff and supports increasing Māori capacity by employing more Māori staff members across different levels of the service as vacancies and applications for employment permit. Māori staff members interviewed confirmed culturally safe support is given to residents and that mana is respected. Ethnicity data is gathered when staff are employed.</p> <p>The facility manager reported they are in the process of contacting local iwi and Māori communities and other services to see if they can provide support for the service.</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>	<p>FA</p>	<p>There are policies in place around Tongan, Samoan and Cook Island culture available to staff. There are a range of associated cultural assessments and care plans for the registered nurses (RNs) to access if there was a resident who identified with any of the Pacific Island cultures. The policies commit to providing appropriate and equitable care and includes consideration of spiritual needs in care planning for residents who identify as Pasifika. Cultural safety support training has been provided to staff annually (December 2021).</p> <p>There were no staff or residents identifying as Pasifika at the time of the audit. The owners interviewed describe how they support applicants and are open to increasing Pasifika staff in all levels of the service as vacancies and applications for employment permit.</p> <p>Residents can identify individual spiritual, cultural and other needs as part of the care planning process and this was consistently seen in all sampled residents' files.</p> <p>The service is working towards developing Pacific policies further and a Pacific health plan in partnership with local Pasifika communities or groups. Links are yet to be made with the local Pasifika community. Family/whānau interviews stated that they</p>

		<p>were satisfied with the choices they were provided regarding their care, activities and the services provided.</p> <p>Information gathered during assessments includes identifying a resident's specific cultural needs, spiritual values, and beliefs. Assessments also include obtaining background information on a resident's cultural preferences, which includes (but is not limited to), beliefs, cultural identity, and spirituality. This information informs care planning and activities that are tailored to meet identified needs and preferences.</p> <p>Ashlea Grove is working towards developing relationships with Pacific communities and organisations, to enable better planning, support, interventions, research, and evaluation of the health and wellbeing of Pacific peoples to improve outcomes.</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>The staff interviewed understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents following their wishes. Family/whānau and residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) and confirmed they were provided with opportunities to discuss and clarify their rights. The Code is available in Māori and English languages.</p> <p>There were residents and staff who identified as Māori. The facility manager and registered nurses reported that the service recognises Māori mana motuhake (self-determination) of residents, family/whānau, or their representatives in its updated cultural safety policy. The assessment and care planning processes include the resident's 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>	FA	<p>The service ensures that residents and whānau are included in planning and care, which is inclusive of discussion and choices regarding maintaining independence. Interviews with staff, residents, relatives, and observation confirmed that individual religious, social preferences, individual values, and beliefs are</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>identified and upheld. These were also documented in resident files.</p> <p>The organisation has a policy on sexuality and intimacy that provides outlines for managing expressions of sexuality. Staff interviews confirmed that they assist residents to choose the clothing they wish to wear. Interviews with residents and relatives confirmed that residents can choose what clothing and adornments to wear each day, including make up if they wish to.</p> <p>Ashlea Grove has policies and procedures in place to ensure that a resident's rights to privacy and dignity is upheld. They provide guidelines for respecting and maintaining privacy and dignity. There are spaces where residents can find privacy within communal areas.</p> <p>Staff were observed to knock on bedroom and bathroom doors prior to entering, ensure that doors are shut when personal cares are being provided and residents are suitably attired when taken to the bathroom. Interviews and observation confirmed that staff maintain confidentiality and are discrete, holding conversations of a personal nature in private. The residents and relatives interviewed reported that resident privacy is respected. Satisfaction survey results evidenced a high level of satisfaction around privacy.</p> <p>Staff receive training in cultural safety. Culturally appropriate activities have been introduced such as celebrating Waitangi Day and Matariki.</p> <p>Interviews with staff confirmed that understanding of the cultural needs of Māori, including in death and dying, as well as the importance of involving family/whānau in the delivery of care. Values and beliefs are identified, upheld, and are inclusive of tāngata whaikaha needs to enable their participation in te ao 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>FA</p>	<p>Staff at Ashlea Grove understand the service's policy on abuse and neglect, including what to do should there be any signs. The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of</p>

<p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>		<p>conduct. A code of conduct statement is included in the staff employment agreement.</p> <p>Residents reported that their property and finances are respected. Professional boundaries are maintained. The facility and registered nurses reported that staff are guided by the code of conduct to ensure the environment is safe and free from any form of institutional and systemic racism. Family members stated that residents were free from any type of discrimination, harassment, physical or sexual abuse or neglect and were safe. Policies and procedures such as the harassment, discrimination, and bullying policy are in place. The policy applies to all staff, contractors, visitors, and residents. The owners, GP, registered nurses, and caregivers stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents. There were no documented incidents of abuse or neglect in the records sampled.</p> <p>There are systems in place to manage residents' petty cash.</p> <p>The Māori health care plan in place identifies strengths-based, person-centred care and general healthy wellbeing outcomes for Māori residents.</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. 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. Relatives stated they were kept well informed about any changes to their relative's health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records and incident reports reviewed. Staff understood the principles of open disclosure, which are supported by policies and procedures.</p> <p>Personal, health, and medical information from other allied health care providers is collected to facilitate the effective care of residents. Each resident had a family or next of kin contact section in their file.</p> <p>There were no residents who required the services of an</p>

		<p>interpreter; however, the staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and use family members and staff as appropriate.</p> <p>Residents and relatives reported they were well informed throughout Covid lockdown of all the changes and current visiting arrangements.</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 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>FA</p>	<p>Staff interviewed understood the principles and practice of informed consent. Informed consent is obtained as part of the admission documents which the resident and/or their nominated legal representative signed on admission. Signed admission agreements were evidenced in the sampled residents' records. Informed consent for specific procedures had been gained appropriately.</p> <p>Consent for residents in the dementia unit were signed by the residents' legal representatives. Resuscitation treatment plans were signed by residents who are competent and able to consent, and a medical decision was made by the general practitioner (GP) for residents who were unable to provide consent. The RN reported that the GP discusses the resuscitation treatment plan with the resident, where applicable, or with the resident's family/whānau as verified in interviews with residents, their family/whānau and the GP. Staff were observed to gain consent for daily cares.</p> <p>Residents confirmed that they are provided with information and are involved in making decisions about their care. Where required, a nominated support person is involved (eg, family/whānau), with the resident's consent. Information about the nominated residents' representative of choice, next of kin, or enduring power of attorney (EPOA) is provided on admission. Residents in the dementia unit had activated EPOAs in their files. Communication records verified inclusion of support people where applicable. The informed consent policy considers appropriate best practice tikanga guidelines in relation to consent.</p> <p>There are two shared rooms in the dementia unit. There is a policy in place which provides the registered nurse with the process of assessing residents' compatibility for sharing a room. The 'checklist</p>

		for evaluating shared room placement' for staff to complete, is in line with standard E3.3 section b and c of the ARC agreement. There is a consent form specific to shared rooms to be signed by both relatives/EPOA.
<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>	FA	<p>Ashlea Grove has a complaints policy and process to manage complaints in line with Right 10 of the Code. The complaint process is made available in the admission agreement and explained by the facility manager or registered nurse on the resident's admission. The complaint forms are available at the entrance of the facility.</p> <p>The facility manager is responsible for managing complaints. A complaints register is in place that includes the name of the complainant, date the complaint is received, the date the complaint was responded to, the date of the resolution, as well as the date the complaint is signed off. Evidence relating to the complaint is held in the complaints register. Interview with the facility manager and a review of the complaint made, indicated that complaints are investigated promptly, and issues are resolved in a timely manner. Complaints (when there are any) are discussed at staff meetings. There have been no complaints since 2019.</p> <p>Interviews with the owners, staff and relatives confirmed that residents are able to raise any concerns and provide feedback on services and this includes discussing and explaining the complaints process. Relative interviews confirmed that they are aware of the complaints process and stated that they had been able to raise any issues directly with the facility manager or registered nurses. The facility manager reports complaint forms can be available in a range of languages where required.</p> <p>There have been no complaints received from external agencies since the previous audit.</p>
<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the</p>	FA	<p>Ashlea Grove is privately owned and provides rest home and dementia level of care for up to 37 residents (20 rest home beds and 17 dementia beds). On the day of the audit, there were 29</p>

<p>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 highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>		<p>residents (12 rest home level including two residents on long term support- chronic health contract (LTS-CHC), and 17 dementia level). All other residents were under the age-related residential care (ARRC) contract. The facility has two shared rooms in the dementia unit, one room is currently being shared by two residents.</p> <p>The owners/managers (husband/wife team) have managed the facility since 2015 and fully owned the facility since December 2021. One owner/manager is responsible for the general day to day non-clinical running of the facility. The other owner is the operation's manager and is responsible for health and safety, human resources, and maintenance. They are supported by two part-time registered nurses (RN) with experience in aged care. Both have a current annual practising certificate.</p> <p>The owners have overall responsibility for the development and implementation of the quality and risk programme, including the implementation and close out of corrective actions. Ashlea Grove has a business plan for 2022-2024. This includes the mission statement that sets out the vision and values of the service. The plan identifies strengths, weaknesses, threats, and opportunities, and includes goals and aspirations. The plan is reviewed at least annually.</p> <p>The business plan commits to identifying and minimising barriers to provide equitable services for all residents (including residents who identify as Māori and residents with disabilities) in the service. The owners and staff work alongside residents (where appropriate) and whānau during the care planning process and any decision making around referral. The service has good relationships with members of the allied health teams including the physiotherapist, needs assessment team, and Te Whatu Ora. The service ensures all residents receive the information and services to meet the residents' needs, to enhance positive health outcomes for all residents residing in the facility.</p> <p>The owners/managers have attended at least eight hours of training relating to managing a rest home including attendance at aged care provider meetings and in-house management training.</p> <p>The owners are working towards developing relationships with</p>
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	<p>Māori in the local community to ensure high quality service is provided to residents who identify as Maori. The service is working towards how they can establish that link into business planning and policy reviews. Cultural assessments and care plans are based on Te Whare Tapa Whā Maori model of care. Staff interviewed stated they focus on improving outcomes for all residents including Māori and people with disabilities. The owners have both completed education in cultural safety, Te Tiriti o Waitangi and understand the principles of equity. The service has recently purchased new policies from an external contractor to align with the Ngā Paerewa Standard, which includes a comprehensive Māori health plan.</p> <p>Partial Provisional:</p> <p>The service has applied for a reconfiguration of beds (letter dated 1 June 2022) to include: an increase of 8 dementia beds from 17 to 25; downsizing of the rest home unit from 20 to 10 beds; building of a new outside area; extra day room; and a new office. This will decrease bed numbers overall from 37 to 35 as the rooms currently used as double rooms will only be used for single occupancy. There is no proposed date of opening as the reconfiguration of the building has yet to occur.</p> <p>There is a transition plan documented to include communication with the current rest home residents and families to relocate rooms. At this stage there are no plans to increase staffing; however, this will be reviewed as need arises. There are plans in place to increase the activities hours once occupancy increases. The facility manager will ensure all caregivers working in the dementia unit have completed or are working towards completion of the required dementia standards. Currently there are a total of fifteen caregivers; seven have completed the dementia standards, three are in the process of completing, and there are four casual staff. Currently all staff rotate between the dementia and rest home units. The facility manager has also completed the dementia standards.</p> <p>The fire department have sighted the plans and confirm there will be no changes to the fire evacuation plan with the moving of the door to close off the extended dementia unit. Following the completion of ensuring the internal and external areas of the dementia unit are fully completed and secure, the area will be</p>
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		suitable for dementia level residents.
<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>	FA	<p>The service has a quality and risk management plan that is reviewed annually and developed with input from facility staff. The plan outlines the quality and risk management framework to promote continuous quality improvement. The service has purchased policies to meet the Ngā Paerewa 2021 Services Standard from an external consultant and is working towards implementation of these (link 2.1.11).</p> <p>There is an implemented annual schedule of internal audits. Areas of non-compliance from the internal audits include the implementation of a corrective action plan with sign off by the facility manager when completed. Identified trends are raised for discussion within the quality meetings.</p> <p>The registered nurses collate a range of data monthly including (but not limited to), infections, incidents and accidents, and internal audit results. Corrective actions (where identified) are completed and signed off.</p> <p>Quarterly meetings are held with staff where a variety of topics are discussed including outcomes of the falls prevention meeting; resident meetings; management meetings; key performance indicators (KPI) data results; and corrective actions. The staff interviewed could easily describe discussions held at daily handovers and at meetings around KPI data and associated corrective actions.</p> <p>The health and safety officer (owner/ director) oversees the health and safety programme. Health and safety is discussed at staff meetings. Completed hazard identification forms reviewed and staff interviews confirmed that hazards are identified. The hazard register is relevant to the service, available to staff and has been regularly updated and reviewed. The director is responsible for maintenance which is attended to immediately. The health and safety officer attends staff meetings annually or as required. All contractors' complete annual inductions around hazard management and health and safety related to the rest home and</p>

		<p>dementia unit.</p> <p>The facility follows the adverse event reporting policy for external and internal reporting (where required) to reduce preventable harm by supporting system learnings. There was an outbreak in 2022, appropriate notifications were made in a timely manner. Section 31 notifications have not been required. There have been two outbreaks of Covid-19 since the previous audit. These were appropriately notified to the Public Health team and Te Whatu Ora.</p> <p>A sample of 12 incident reports were reviewed. All were fully completed and detailed a description of the incident and resident's injury. There was evidence of timely RN notification (when not on site) and follow up. Neurological observations were fully completed and signed off by the RN. All reports reviewed were signed off as reviewed by the manager. All resident falls are analysed to identify the root cause and prevent future falls.</p> <p>Training around cultural safety was held in December 2021 and training records evidenced a high attendance. Further training around the Treaty of Waitangi is planned to be rolled out to staff. All staff interviewed could easily describe ways to provide high quality care for Māori residents based on past experiences. The organisation is working towards how they can improve health equity through critical analysis of organisational practice.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The owner/managers are both on site 40 hours per week. The owner/managers are on-call after hours for any non-clinical issues and a registered nurse is on call for any clinical issues. The local general practitioner (GP) also provides after-hours care if required. Interviews with caregivers, residents and relatives identified that staffing is adequate to meet the needs of residents. The owners advised that extra staff can be called on for increased resident requirements.</p>

		<p>There is an RN on site from 9 am to 5 pm during weekdays.</p> <p>The rest home (20 beds with 12 rest home residents including one LTS-CHC): There is one senior caregiver 7 am to 3 pm, and one caregiver 8 am to 9 am. Afternoon shifts have one senior caregiver 3 pm to 11 pm and one caregiver 6 pm to 7 pm, and one senior caregiver on the night shift.</p> <p>The dementia care unit (17 dementia beds with 17 residents): There is one senior caregiver rostered from 7 am to 3 pm and one caregiver rostered from 7 am to 2 pm. The afternoon shift has one senior caregiver rostered from 3 pm to 11 pm and one caregiver from 5 pm to 9.30 pm. One senior caregiver is rostered on the night shift.</p> <p>The diversional therapist is scheduled between 10.30 am to 5 pm Tuesday to Friday across both units with activities scheduled in the dementia unit in the afternoon.</p> <p>Extra short shifts can be added when required. Staff and residents interviewed, confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time.</p> <p>The in-service education programme for 2021 has been completed and the plan for 2022 is being implemented.</p> <p>The registered nurses are able to attend external training, including sessions provided by the local hospital and through hospice. One RN has maintained their interRAI competency. Eight hours of staff development or in-service education has been provided annually. Fifteen permanent staff (including an RN, the cook, one kitchen hand, one cleaner) have completed first aid training. There is at least one member of staff on duty with a current first aid certificate at any one time.</p> <p>There are 11 regular caregivers who work in the dementia unit. Seven have completed the required dementia unit education modules. Five are in the process of completing the modules. These staff have been employed within the last 18 months. There is one caregiver who works in the rest home who has completed the dementia modules. Four caregivers across the rest of the facility have completed level 4 NZQA. Training included in the education</p>
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	<p>plan includes (but is not limited to): challenging behaviour; restraint minimisation; infection control; abuse and neglect; delirium; dementia; falls prevention; cultural safety; fire safety; civil defence; health and safety; and Code of Rights/ consent/ advocacy. The service is working towards collecting and sharing high quality Māori health information.</p> <p>All staff complete competencies on orientation to the role and then annually, including: fire; manual handling; health and safety; medications; infection control, including standard precautions; hand washing; and donning and doffing of personal protective equipment. Staff have completed training around outbreak management.</p> <p>Support systems promote health care and support worker wellbeing, and a positive work environment was confirmed in staff interviews. Employee support services are available as required. The staff interviewed all agreed there was a good culture of teamwork within the staff.</p> <p>Partial Provisional:</p> <p>The owners know and understand the requirements for rest home and dementia staffing based on previous experiences, and previous part-ownership in the family business running three other facilities (two dementia units and one rest home/ hospital) in the region. There are no immediate changes planned to existing staff numbers of allocated hours. The managers interviewed stated an understanding of the skill mix required for the acuity of the residents and flexibility in the roster to extend hours to meet the needs of the residents. The transition plan describes a rostering plan which will increase current staffing as resident occupancy increases. Once resident numbers in the dementia unit reaches 20, another short shift will be added, and a full shift will be added when full occupancy of 25 is reached. The owners will continue to ensure all staff members who will be working in the dementia units have completed the required training. The activities in the dementia unit will increase by an hour when occupancy reaches 23. There is provision to increase this further depending on the residents at the time. Nursing hours will increase as required during the increase of occupancy. There is sufficient staff employed with the required</p>
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		<p>dementia training for the first phase of the increased occupancy of the extended dementia unit.</p>
<p><b>Subsection 2.4: Health care and support workers</b></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 reflect standard employment practices and relevant legislation. All new staff are police checked, and referees are contacted before an offer of employment occurs. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented. Each position has a job description. A total of five staff files were reviewed (registered nurse, activities coordinator, and three caregivers). Staff files included: reference checks; police checks; appraisals; competencies; individual training plans; professional qualifications; orientation; employment agreement; and position descriptions.</p> <p>There is a separate folder with copies of all RNs, EN, GP, and dispensing pharmacists' current practising certificates from their regulatory bodies. Each of the sampled personnel records contained evidence of the new staff member having completed an induction to work practices and standards and orientation to the environment including management of emergencies. Staff performance is reviewed and discussed at regular intervals. Copies of current appraisals for staff were sighted.</p> <p>The ethnic origin for each staff member is documented on their personnel records. A spreadsheet of staff qualifications and ethnicity is maintained by the facility manager. Following incidents, the clinical manager and facility manager are available for any required debrief and discussion.</p> <p>Staff interviewed and minutes of meetings confirm debrief sessions were held following the Covid outbreaks.</p> <p>Partial Provisional:</p> <p>The owners stated being aware of the Age-Related Residential Care Service (ARRC) contract requirements for staff training. Staff confirmed staffing numbers at present are adjusted to meet the needs of the residents. The current staff are all orientated to the</p>

		<p>whole facility and working with residents in the dementia unit. The current staff are familiar with fire procedures and there have been regular six-monthly fire drills held. There are no changes to the current fire exits in the facility.</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>Residents' records are managed in a paper-based format, while medicines are managed in an electronic system. Residents' information, including progress notes, is entered into the resident's record in an accurate and timely manner. The name and designation of the person making the entry is identifiable. Residents' progress notes are completed every shift, detailing residents' response to service provision.</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of their obligations to maintain the confidentiality of resident information. Resident care and support information can be accessed in a timely manner and is protected from unauthorised access. Any hard copy information is locked away when not in use. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the residents' family where applicable.</p> <p>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. The service is not responsible for registering residents with the National Health Index (NHI).</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</p>	<p>FA</p>	<p>The information pack has accurate information about the services provided. The entry criteria is clearly communicated to people, whānau, and where appropriate, to local communities and referral</p>

<p>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. 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>		<p>agencies, verbally on enquiry.</p> <p>Residents are assessed by needs' assessment and coordination service (NASC) prior to their entry to the service. Where applicable the enduring power of attorney (EPOA) have consented for admission of residents in the dementia unit. In the records reviewed, there were signed admission agreements and consent forms. Family/whānau and EPOAs interviewed stated they were satisfied with the admission process and the information that was made available to them on admission.</p> <p>Residents' information is kept confidential in secure cupboards. The RN stated that any delay to entry to service would be discussed with the resident or family/ whānau as required.</p> <p>The RN and facility manager reported that entry to service can be declined if there is no vacancy, or the prospective resident does not meet the entry criteria. The resident and family/whānau are informed of the reason for the decline and of other options or alternative service. Records are maintained of enquiries and of those declined entry. The pre-admission information form includes ethnicity data. Work is in progress to implement routine analysis of entry and decline rates including specific data for entry and decline rates for Māori. The owners are working towards developing relationships with local iwi and Māori communities in the area to support residents and whānau who identify as Māori. Currently there are residents who identify as Māori. The staff interviewed were knowledgeable around the resident's preferences and whānau involvement.</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</p>	<p>PA Low</p>	<p>Five resident files were sampled for review (three rest home, and two dementia level of care). The registered nurses (RNs) are responsible for completing the admission assessments, care plans and evaluations. There is evidence of family/ whānau involvement in the care plans and interRAI assessments. The initial nursing assessments and initial care plans sampled were developed within 24 hours of an admission in consultation with resident's and family/ whānau. The assessment tools include consideration of residents'</p>

<p>to support wellbeing.</p>		<p>lived experiences, cultural needs, values, and beliefs. Initial interRAI assessments were completed within three weeks of an admission and six-monthly reassessments were completed.</p> <p>The contracted general practitioner (GP) visits the service weekly. As well as this, there is a further planned morning session available for acute medical issues. The GP is also available for after hours on-call consultations when required. Medical assessments are completed by the GP within two to five working days. Routine medical reviews are completed three-monthly. More frequent reviews were completed if required, as determined by the resident's needs. Medical records were evidenced in sampled records. During interview, the GP confirmed they were contacted in a timely manner when required, that medical orders were followed, and care was implemented promptly.</p> <p>The Māori health and wellbeing assessments support kaupapa Māori perspectives throughout the assessment process. The Māori health care plan was developed in consultation with a cultural advisor. The Māori health care plan in place reflects the partnership and support of residents, whānau, and the extended whānau as applicable, to identify their own pae ora outcomes in their care and support wellbeing. Tikanga principles are included within the Māori health care plan. Any barriers that prevent tāngata whaikaha and whānau from independently accessing information or services are identified and strategies to manage these documented. The staff confirmed they understood the process to support residents and whānau. There were residents who identify as Māori at the time of the audit. Cultural assessments in the files reviewed were completed by the RNs who have completed cultural safety training.</p> <p>The long-term care plans were developed within three weeks of an admission. A range of clinical assessments, referral information, observation and the NASC assessments served as a basis for care planning. Residents' and family/whānau representatives of choice and EPOAs for residents in the dementia unit were involved in the assessment and care planning processes, as confirmed in interviews with residents, family/whānau and EPOAs. All residents' files sampled had current interRAI assessments completed.</p> <p>The long-term care plans sampled identified residents' strengths,</p>
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		<p>goals, and aspirations. Where appropriate, early warning signs and risks that may affect a resident's wellbeing were documented. Management of specific medical conditions was well documented with evidence of systematic monitoring and regular evaluation of responses to planned care. However, interventions did not all reflect current care and management of identified risks.</p> <p>The care plans evidenced service integration with other health providers including medical and allied health professionals. There is a contracted podiatrist who visits the service six-weekly, and a contracted physiotherapist. Resident progress notes were clearly written, informative and relevant. 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. Examples of evidence of referrals sent to specialist services included referrals to the mental health services for older adults, wound care nurse specialist and radiology department.</p> <p>There is a range of monitoring charts available for staff to utilise. Monitoring charts sighted included (but not limited to): vital signs, resident weight, and behaviour charts; however, not all restraint monitoring was evidenced as occurring (link 6.2.2).</p> <p>There were three active wounds at the time of the audit and no pressure injuries. Wound management plans were implemented with regular evaluation completed.</p> <p>Residents' care is evaluated on each shift and reported in the progress notes by the caregivers. Any acute changes of health is reported to the RN, as confirmed in the records sampled. The long-term care plans reviewed had been evaluated at least six-monthly following interRAI reassessments and risk assessments; however, not all care plan evaluations were reflective of resident goals.</p> <p>Short-term care plans are completed for acute conditions. Short-term care plans reviewed have been evaluated weekly or earlier if clinically indicated. Where progress was different from expected, changes to the care plan was completed. Where there was a significant change in the resident's condition, an interRAI reassessment was completed and a referral made to the local</p>
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		<p>NASC team for reassessment for level of care.</p> <p>Caregivers and registered nurses described the detailed handover provided at the beginning of each shift which they all attend.</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 equipment and resources were adequate to support the residents in the reconfigured dementia unit with full occupancy when opened. The residents and family/whānau 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. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. 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 activity programme is led by an activity coordinator who is in the process of completing a recognised New Zealand qualification. The activities programme covers seven days a week. The weekly activities programme is posted on noticeboards around the facility. Residents are invited to the activities on the programme each day by the activity coordinator.</p> <p>Residents' activity needs, interests, abilities, and social requirements are assessed on admission with input from residents, family/whānau and EPOAs. Activities plans are developed as part of the long-term care plans. The activities programme is regularly reviewed through satisfaction surveys, residents' meetings, and one-on-one conversations with residents to help formulate an activities programme that is meaningful to the residents. Care plans reviewed identified a range of activities the resident enjoys across 24-hours.</p> <p>Resident's activity needs are evaluated as part of the formal six-monthly interRAI assessments and care plan review and when there is a significant change in the resident's ability. This was evident in the records sampled and confirmed in interviews with the activities team, residents and EPOAs (for residents in the dementia unit).</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. The activities programme includes exercises, van trips, puzzles, quiz, walks, and birthday celebrations. International days are celebrated. Daily activities attendance records are maintained.</p> <p>Residents were observed participating in a variety of activities on the days of the audit. Competent residents in the rest home are supported to access community events and have the independence of going out on their own if able. Interviewed residents, family/whānau and EPOA confirmed they find the programme satisfactory.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living with dementia. The residents had free access to the secure garden. Activities in the dementia unit includes one-on-one short walks in the secure garden, hand and foot massage, nail care, pet therapy, van outings, colouring, arts, and crafts, and daily works. The residents in the secure unit can join the activities group for the rest home level residents with an escort if desired. The activity coordinator reported that the activities are flexible and can be changed to meet the needs of the residents.</p> <p>Partial Provisional</p> <p>Appropriate resources are already available for the activities programme in the reconfigured dementia unit and the designated storage area and supplies were sighted. The activities staff member will cover the activities for the residents in the reconfigured dementia unit. There is provision to extend activities as required, included in the transition plan.</p>
<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and</p>	<p>FA</p>	<p>The implemented medicine management system is appropriate for the size and scope of the service. The medication management</p>

<p>timely manner.  Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.  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>policy identifies all aspects of medicine management in line with current legislative requirements and safe practice guidelines. The service uses an electronic medication management system. The caregivers 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 have a current medication administration competency. Regular medication management education was completed.</p> <p>Medicines are 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. The GP interviewed stated that over the counter medication and supplements will be documented on the medicine charts where required. 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. Standing orders are not used.</p> <p>The service uses blister packed medication. The medication and associated documentation are stored safely in the nurses' stations with restricted access and medication trolley. Medication reconciliation is conducted by the RNs when regular medicine packs are received from the pharmacy and when a resident is transferred back to the service. This was verified in medication records sampled. All medications in the medication storage cupboard in the rest home area and both medication trolleys (one for each unit) were within current use by dates. 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. Opened eyedrops were dated.</p> <p>There is an implemented process for analysis of medication errors and corrective actions implemented as required. Medication audits were completed with corrective action plans implemented.</p>
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		<p>Partial Provisional</p> <p>The reconfigured dementia unit will have a new secured medication cupboard with hand washing facilities and workspace (yet to be built). This area is planned to be situated in the office area near where the current entrance to the facility is. Another lockable medication trolley is yet to be purchased which will be stored in the medication room. The medication room and medication processes in the rest home area will remain unchanged. The current policies and procedures will continue to be used. The manager advised that at least one staff member on each shift in each unit will have medicine competency.</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. Copies of individual dietary preference were available in the kitchen folder. The food is prepared on site by two cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns in a four-weekly cycle. The menu is reviewed regularly. The food is transported to the dining room in the dementia unit and to the rest home in bain-maries.</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 of Primary Industries. The current food control plan will expire in September 2023. Food temperatures were monitored appropriately and recorded as part of the plan. On the days of the audit, the kitchen was clean and well equipped with special equipment available. Kitchen staff were observed following appropriate infection prevention measures during food preparation and serving.</p> <p>Residents' weight is monitored regularly by the RNs and there was evidence that any concerns in weight identified were managed</p>

		<p>appropriately. Additional supplements were provided where required. The cook stated that if any residents request for culturally specific food, including menu options culturally specific to te ao Māori, this is offered as requested. Residents who identify as Māori were satisfied with the food services. Whānau are welcome to bring culturally specific food for their relatives.</p> <p>Mealtimes were observed during the audit. Residents received the support they required and were given enough time to eat their meal in an unhurried fashion. Residents who chose not to go to the dining room for meals, had meals delivered to their rooms. Meals going to rooms on trays had covers to keep the food warm. Residents' expressed satisfaction with meals. This was verified in satisfaction surveys and residents' meetings minutes. Nutritious snacks are available at all times in the unit.</p> <p>Partial Provisional:</p> <p>The dining room is yet to be refurbished (link 4.1.1). There is adequate space in the proposed dining room for adequate tables and chairs. All the meals for the new dementia unit will be provided from the main kitchen, using the existing menu and food control plan, and transported by a bain-marie. Snacks will continue to be available for residents in the dementia unit on a 24-hourly basis.</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>	<p>FA</p>	<p>The transfer and discharge policy guide staff on transfer, exit and discharge processes. Transfers and discharges are managed efficiently in consultation with the resident, their family/whānau and the GP. Standard transfer forms are used to transfer residents to acute services. 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 situations. 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 in the sampled files. The transfer and discharge planning included risk mitigation and current needs of</p>

		<p>the resident. Referrals to other allied health providers to ensure safety of the residents were completed.</p> <p>Residents are supported to access or seek referral to other health and/or disability service providers. The RN reported that social support or Kaupapa Māori agencies, where indicated or requested, will be provided. Referrals to seek specialist input for non-urgent services are completed by the GP or the clinical team. Examples of referrals completed were in residents' files sampled.</p> <p>Family/whānau are kept informed of the referral process, reason for transition, 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 belonging, independence, interaction, and function.</p>	<p>PA Low</p>	<p>The building has a current Form 12 (expiring in June 2023) displayed instead of a building warrant of fitness due to Covid-19. This certificate declares all emergency equipment is safe and the building complies with regulations. The owner/ director is responsible for maintenance. There is a maintenance book for staff to record any issues. As director is on site daily, any maintenance issues are attended to immediately. Hot water temperatures are monitored routinely, and records evidenced these are within expected ranges. External contractors including plumbers and electricians are available as needed. All equipment is tagged and tested annually. Gardens are well maintained.</p> <p>The current rest home area has large resident rooms. Ten of the resident rooms (which will continue to be the rest home unit) have toilet and handbasins. There are communal shower facilities within short distances of resident rooms. Corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids. There is an open plan lounge/ dining area where resident activities take place. External areas are well maintained and provide seating and shade. All areas are easily accessible to residents using mobility aids.</p> <p>The current secure dementia unit has wide corridors, with three lounge areas. One smaller sensory lounge, one TV lounge away</p>

		<p>from the other lounge areas and one lounge area off of the dining area. All communal areas are accessible and well utilised by residents. The dining area is separated from the lounge and provides adequate space for residents to move around freely. The communal shower and toilet areas are easily identifiable and provide privacy. There are outdoor areas that are secure and provide paths and areas of interest, and seating and shade.</p> <p>The facility is heated by radiators which are regulated to prevent burns. All resident areas have large windows. There is hand sanitiser available within easy reach throughout the facility, where there are no hand basins in resident rooms.</p> <p>The management team reported that they plan to engage with a Māori representative around the planning of the reconfigured dementia unit to ensure the unit reflects the values of Māori culture.</p> <p>Partial Provisional.</p> <p>The service has applied for a reconfiguration of beds to increase the dementia beds and reduce the rest home beds. The proposed dementia area is yet to be secure, planned outdoor areas are yet to be built and made secure, and the door to close off the rest home area is yet to be moved.</p> <p>The proposed changes to the facility include moving the door and temporary partition (existing entrance) to the current dementia unit around, to close off the corridor to the rest home area. This will open up the dementia unit to the current main foyer and front door area to encompass the original part of the building. The current front door will be replaced, and the outdoor area made secure. There are plans in place to build a large secure decked area at the other end of the new dementia unit, which will provide outdoor areas at each end of the unit and a smaller outdoor area in the middle (existing main entrance).</p> <p>The new unit will include a new office for the facility manager and a nurse's station, and a small dining and lounge area, which will provide a small-homely feel.</p> <p>The completed dementia unit will be across the length of the original part of the facility; corridors are wide and residents will</p>
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		<p>have space to wander freely in loops. Current resident rooms are large and provide space for residents to move around freely. Windows have been locked so they only open so far. There are adequate communal showers and toilets which are easily identifiable and provide privacy for residents. The proposed lounge and dining area (currently a resident's room) will provide adequate space for seating and dining tables, this is yet to be refurbished. There is another large room (currently not utilised) which could be utilised for a separate lounge and is situated where the entrance to the new deck will be. The current double rooms in the dementia unit will be used for single occupancy only.</p> <p>There are three existing external doors to the rest home area which will continue to be used. A ramp will be built to provide access to the corridor where the nurses station is currently situated. Two doors enter the end of the corridor where the 10 rest home resident rooms are.</p> <p>The only change there will be to the rest home area is that all resident rooms will be in the 'new' part of the building.</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>	FA	<p>There is an emergency management plan to guide staff in managing emergencies and disasters. The facility has an approved fire evacuation plan. Fire evacuation drills are completed every six months. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>Civil defence supplies are checked six-monthly. The facility has back-up lighting, power and sufficient food and personal supplies to provide for its maximum number of residents in the event of a power outage and portable gas heaters would provide alternative means of heating. Training in civil defence occurred in July 2022. There is sufficient water stored to ensure enough for three litres per day, for three days, per resident. There are alternative cooking facilities available with a gas barbeque. In the case of residents requiring to be evacuated, there is an agreement in place with sister facilities in Dunedin and a facility in Balclutha.</p> <p>Staff are responsible for checking the facility for security purposes</p>

		<p>on the afternoon and night shifts. Surveillance cameras are situated in three hallways and the kitchen.</p> <p>There are call bells in the residents' rooms and ensuites, communal toilets and lounge/dining room areas. Residents were observed to have their call bells in close proximity. There is at least one staff member on each shift with a current first aid certificate.</p> <p>Partial Provisional:</p> <p>The fire department has been to review the building and reconfiguration plans. There will be no changes required to the fire evacuation plan as no changes are being made to existing fire cells or fire doors. The 'new' unit is yet to be secured (link 4.1.1)</p>
<p><b>Subsection 5.1: Governance</b></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 registered nurse is the infection control coordinator. The infection control coordinator reported that they have full support from the manager regarding infection control matters. This includes time, resources, and training. Monthly management meetings (attended by the owners) include discussions regarding any residents of concerns, including any infections. All policies, procedures, and the pandemic plan have been updated to include Covid-19 guidelines and precautions, in line with current Te Whatu Ora - Health New Zealand recommendations.</p> <p>The service has a clearly defined and documented infection control and antimicrobial stewardship (AMS) programme implemented that was developed by an external contractor and aligns with the Ngā Paerewa Standard. The infection control programme was approved by the owner/directors and is linked to the quality improvement programme. The infection control programme is reviewed annually.</p> <p>The infection prevention (IP) and Antimicrobial Stewardship (AMS) policies were developed and align with the strategic document and approved by governance and linked to a quality improvement programme. The infection control coordinator described relationships with Te Whatu Ora infection control specialists, the microbiologist and can seek advice form the GP.</p>

		<p>Partial Provisional Audit:</p> <p>The staff and owner/directors demonstrated an understanding of the infection prevention and control programme covering the existing wing and the new secure dementia unit. There was adequate personal protective equipment (PPE) in stock.</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>FA</p>	<p>The RN oversees and coordinates the implementation of the infection control programme. The job description defines the role, responsibilities, and reporting requirements. The infection control coordinator has completed external education and has access to shared clinical records and diagnostic results of residents.</p> <p>The infection control coordinator has appropriate skills, knowledge, and qualifications for the role, having completed online infection prevention and control training as verified in training records sighted. Additional support and information are accessed from the infection control team at the local Te Whatu Ora Southern, the community laboratory, and the GP, as required. The infection control coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The Māori health plan ensures staff is practicing in a culturally safe manner.</p> <p>The pandemic and infectious disease outbreak management plan in place is reviewed at regular intervals. Sufficient infection control resources including personal protective equipment (PPE) were available on the days of the audit. Personal protective equipment stocks were readily accessible to support the pandemic response plan if required.</p> <p>Staff have received education around infection control at orientation and through ongoing annual online education sessions. Additional staff education has been provided in response to the Covid-19 pandemic. Education has been on an individual basis and as a group in residents' meetings. This included reminders about handwashing and advice about remaining in their room if they are unwell. This was confirmed in interviews with residents.</p>

		<p>The infection control coordinator liaises with the manager around PPE requirements and procurement of the required equipment, devices, and consumables through approved suppliers and the local Te Whatu Ora. The manager stated that the infection control coordinator has been involved in the consultation process for the reconfiguration of the existing facility.</p> <p>Medical reusable devices and shared equipment are appropriately decontaminated or disinfected based on recommendation from the manufacturer and best practice guidelines. Single-use medical devices are not reused. There is a decontamination and disinfection policy to guide staff. Infection control audits have been completed, and where required, corrective actions 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. The IC coordinator interviewed described some of the culturally safe practices around infection control observed, and thus acknowledge the spirit of Te Tiriti. The RN reported that residents who identify as Māori are consulted on infection prevention and control requirements as needed. Staff stated they understood infection prevention and control requirements. The service is working towards sourcing educational resources in te reo Māori.</p> <p>The current infection control programme and implementation will be used in the reconfigured dementia unit.</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</p>	<p>FA</p>	<p>The antimicrobial stewardship (AMS) programme guides the use of antimicrobials and is appropriate for the size, scope, and complexity of the service. It was developed using evidence-based antimicrobial prescribing guidance and expertise. The AMS programme was approved by the management team. The policy in place aims to promote optimal management of antimicrobials to maximise the effectiveness of treatment and minimise potential for</p>

<p>prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.</p>		<p>harm. Responsible use of antimicrobials is promoted. The GP has overall responsibility for antimicrobial prescribing. Monthly records of infections and prescribed treatment were maintained. The annual infection control and AMS review and the infection control and hand washing audit include the antibiotic usage; monitoring the quantity of antimicrobial prescribed, effectiveness, pathogens isolated and any occurrence of adverse effects. The AMS programme will apply to the reconfigured dementia unit.</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>	<p>FA</p>	<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 definitions are used. Work is in progress to include ethnicity data in surveillance records.</p> <p>Infection prevention audits are completed including cleaning, laundry, and hand hygiene. Relevant corrective actions were implemented where required. Staff reported that they are informed of infection rates and regular audit outcomes at staff meetings. 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 are advised of any infections identified and family/whānau where required, in a culturally safe manner. This was confirmed in progress notes sampled and verified in interviews with residents and family/whānau. There have been two infection outbreaks reported since the previous audit which were managed appropriately with appropriate notification completed. The current surveillance system will be utilised in the reconfigured dementia unit.</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 antimicrobialresistant organisms.</p>	<p>FA</p>	<p>The management of waste and hazardous substances is documented. Domestic waste is removed as per local authority requirements. All chemicals were observed to be stored securely and safely. Material data safety sheets were displayed in the laundry. Cleaning products were in labelled bottles. Cleaners ensure that trolleys are safely stored when not in use. A sufficient amount of PPE was available which includes masks, gloves, goggles, and aprons. Staff demonstrated knowledge on donning and doffing of PPE.</p> <p>Laundry is completed by staff who also work in other roles. A cleaner is designated seven days per week. Cleaning guidelines are provided. Cleaning equipment and supplies were stored safely in locked storerooms. Cleaning schedules are maintained for daily and periodic cleaning. The facility was observed to be clean throughout.</p> <p>The laundry is clearly separated into clean and dirty areas. There is a washing machine and dryer available with processes to ensure safe hygiene requirements. Staff responsible for cleaning and laundry have received training and documented guidelines are available. The effectiveness of laundry and cleaning processes is monitored by the internal audit programme. The staff and cleaner demonstrated awareness of the infection prevention and control protocols. Resident surveys and residents' interviews confirmed satisfaction with cleaning and laundry processes.</p> <p>There are regular internal environmental cleanliness audits.</p> <p>Partial Provisional:</p> <p>The reconfigured dementia unit will use the same cleaning and laundry facilities and staff. Cleaning and laundry chemicals will continue to be stored in the existing secure chemical storage areas.</p>
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving</p>	<p>FA</p>	<p>Maintaining a restraint-free environment is the aim and philosophy of the service. The management team demonstrated commitment to this. Ashlea Grove was restraint free until July 2022. There is</p>

<p>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>currently one resident requiring short-term restraint at the time of the audit, and one resident who occasionally uses restraint. Both residents reside in the dementia unit. The manager and the RNs reported that restraint is used as a last resort for safety when all alternatives have been explored. Restraint is included on the agenda for staff meetings.</p> <p>Policies and procedures meet the requirements of the standards. Both RNs share the restraint coordinator role, and they support and oversee any restraint management. Staff have received training in restraint, de-escalation techniques and challenging behaviour management. The RNs in consultation with the facility manager and GP are responsible for the approval of the use of restraints.</p> <p>Partial Provisional:</p> <p>The organisation is dedicated to ensuring a restraint-free environment. Training around restraint, dementia, and challenging behaviours will continue to be provided on the education plan and be included in the orientation process.</p>
<p>Subsection 6.2: Safe restraint</p> <p>The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort.</p> <p>As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.</p>	<p>PA Moderate</p>	<p>A restraint register is maintained by the restraint coordinators. At the time of the audit, there two residents in the dementia unit (one of whom only occasionally) requiring restraint for safety (both chair restraints).</p> <p>Both resident files were reviewed. The restraint assessment addresses alternatives to restraint use before restraint is initiated (eg, falls prevention strategies, managing behaviours). Cultural considerations are also assessed. Written consents were in place and signed by the resident's EPOA and the GP appropriately. Interventions around restraint and monitoring were not documented in the residents' care plans (link 3.2.3). The restraint assessment addresses the resident's cultural, physical, psychological, and psychosocial needs, and addresses wairuatanga (where applicable) and monitoring requirements; however, monitoring forms have not been accurately completed for each resident using restraint. On further discussion with the manager and registered nurse, these episodes of restraint were a temporary measure as a</p>

		<p>very last resort. The manager and registered nurses described the possibility of reassessment of these residents for an increased level of care but felt this was unlikely due to the reduced psychogeriatric beds in the region, and felt it was worth seeing if the interventions resolved.</p> <p>One resident had a recent infection and had multiple falls with injury including head injury (neurological observations had been fully completed for each fall). Extra support was implemented; however, when the resident was unsettled and stood up, they fell down, reassurance/ distraction around trying to get the resident to stay sitting to prevent falls aggravated the behaviours. The activities coordinator spent a lot of time with this resident as evidenced on progress notes. The restraint was only used in the interim till the effects of the infection resolved and was rarely utilised. The registered nurses, care staff and management reported the resident was getting better, and restraint was rarely utilised as falls and behaviour were reducing and the resident was returning to 'usual' function.</p> <p>The other resident had required restraint due to a deterioration health, increase in falls and a disinterest in food, which has resolved with a change in medications. The restraint was not in use and had not been in use in the weeks up to the audit; however, the resident had not been removed from the register and the care plan not updated (link 3.2.3).</p> <p>The staff and RNs interviewed describe visual monitoring and regular changes of position for the residents when restraint is in use. During the audit, staff were visible and around the residents most of the time unless attending to other residents. The staff interviewed were knowledgeable around the associated risks of using restraint and describe using restraint as a last resort.</p> <p>A policy is in place for the use of emergency restraints. The restraint coordinator stated this has not been required and was able to describe the content of a debrief meeting should this be required in the future. Any accident or incident that occurred as a result of restraint are monitored. No accidents or incidents reported have been as a result of restraint.</p>
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		Residents using restraints are reviewed after the first month and three-monthly thereafter at GP reviews. Residents using restraint are discussed at handovers, management, and staff meetings.
<p>Subsection 6.3: Quality review of restraint</p> <p>The people: I feel safe to share my experiences of restraint so I can influence least restrictive practice.</p> <p>Te Tiriti: Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions.</p> <p>As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.</p>	FA	<p>The restraint programme is planned to be reviewed annually. The facility has (up until July 2022) been restraint free. Meeting minutes reflect discussions on how to minimise the use of restraint and to ensure that it is only used when clinically indicated and when all other alternatives have been tried. Restraint is included in the internal audit schedule; data is collated around restraint and these are included in the management and staff meetings. Both resident restraints were due to be reviewed at the next GP clinical review.</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 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>	PA Low	Evaluations of care and support are completed in a timely manner and reflective of the care the resident requires; however, not all evaluations reviewed were reflective of resident goals.	<p>i). Two of the six care plans reviewed had evaluations documented that were not consistent with the residents’ goals.</p> <p>ii). Three of six care plans reviewed did not document progression towards meeting goals.</p>	<p>i). &amp; ii). Ensure evaluations reflect the current goals of residents.</p> <p>90 days</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>Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.</p>	PA Low	<p>The reconfigured dementia unit will have a medication room in the proposed office area that is yet to be refurbished, fully functional and secure. Advised this will include handwashing facilities and workbench space. A lockable medication trolley is yet to be purchased.</p>	<p>Partial Provisional: (i). The medication room is yet to be built, furnished, fully functional with handwashing facilities and made secure. (ii). A lockable medication trolley is yet to be purchased for the reconfigured dementia unit.</p>	<p>i). &amp; ii). Ensure the medication room is fully functional and made secure and a lockable medication trolley is purchased. Ensure this is verified as suitable by the funder prior to occupancy.  Prior to occupancy days</p>
<p>Criterion 4.1.1 Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples' cultures and supports cultural practices.</p>	PA Low	<p>Partial Provisional: The reconfiguration to extend the dementia unit includes a number of improvements to be completed prior to opening.</p>	<p>Partial Provisional: i). Ensure the proposed area is secure and the rest home area is closed off appropriately. ii). The deck is yet to be built to include planters and areas of interest and made secure. iii). A ramp and new path are yet to be built to provide access to the rest home area. iv). The existing entrance to the facility will need to be made secure. v). The manager's office and nurses' station are yet to be reconfigured, furnished and functional. vi). The proposed new dining room and lounge area is yet to be reconfigured and furnished.</p>	<p>i). – vi). Ensure all building and refurbishments are completed, and the unit is made secure. This will need to be verified by the Funder as suitable prior to occupancy.  Prior to occupancy days</p>

<p>Criterion 6.2.2</p> <p>The frequency and extent of monitoring of people during restraint shall be determined by a registered health professional and implemented according to this determination.</p>	<p>PA Moderate</p>	<p>Monitoring restraint considers detail documented in the restraint assessment, which addresses the resident’s cultural, physical, psychological, and psychosocial needs, and addresses wairuatanga (where applicable); however, monitoring forms have not been completed in a timely manner for each resident using restraint.</p>	<p>The two residents using restraint had no documentation to reflect that monitoring was completed in a timely manner when restraint was utilised.</p>	<p>Ensure there is documented evidence that restraints are monitored when in use and the frequency of monitoring related to risk.</p> <p>60 days</p>
<p>Criterion 6.2.7</p> <p>Each episode of restraint shall be evaluated, and service providers shall consider:</p> <p>(a) Time intervals between the debrief process and evaluation processes shall be determined by the nature and risk of the restraint being used;</p> <p>(b) The type of restraint used;</p> <p>(c) Whether the person’s care or support plan, and advance directives or preferences, where in place, were followed;</p> <p>(d) The impact the restraint had on the person. This shall inform changes to the person’s care or support plan, resulting from the person-centred and whānaucentred approach/reflections debrief;</p> <p>(e) The impact the restraint had on others (for example, health care and</p>	<p>PA Low</p>	<p>Two residents in the dementia unit had interim lap belts in place to manage increase falls during episodes of delirium. However, documentation reviewed did not reflect at least daily evaluations that align with (a) – (n) of this criterion, and the restraint register had not been updated.</p>	<p>i). There is no documented evidence that interim restraint was evaluated daily during the time restraint was being used to manage residents with acute changes in health status.</p> <p>ii). The restraint register had not been updated to reflect restraints no longer in use.</p>	<p>i). Ensure any use of short-term restraint is evaluated on a daily basis and documentation reflects this.</p> <p>ii). Ensure the register is updated when restraint is no longer required.</p> <p>90 days</p>

<p>support workers, whānau, and other people);</p> <p>(f) The duration of the restraint episode and whether this was the least amount of time required;</p> <p>(g) Evidence that other de-escalation options were explored;</p> <p>(h) Whether appropriate advocacy or support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the person;</p> <p>(j) Future options to avoid the use of restraint;</p> <p>(k) Suggested changes or additions to de-escalation education for health care and support workers;</p> <p>(l) The outcomes of the person-centred debrief;</p> <p>(m) Review or modification required to the person's care or support plan in collaboration with the person and whānau;</p> <p>(n) A review of health care and support workers' requirements (for example, whether there was adequate senior staffing, whether there were patterns in staffing that indicated a specific health care and support workers issue, and whether health care and support workers were culturally competent).</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.