

# Elsdon Enterprises Limited - Annaliese Haven Rest Home

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## Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

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

The specifics of this audit included:

<b>Legal entity:</b>	Elsdon Enterprises Limited
<b>Premises audited:</b>	Annaliese Haven Rest Home
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 3 October 2023 End date: 3 October 2023
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	57

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Analiene Haven provides rest home, hospital and dementia care services for up to 62 residents.

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

Strengths of the service include the supportive staff team and the building refurbishment works that are being undertaken. A total of seven areas of improvement were identified during the audit. Four are new areas of improvement including the equity of the complaints process, the review of quality outcomes, staff competencies, and infection surveillance and analysis. Three areas of improvement identified at the previous audit, relating to the analysis of quality data, the activity program, and care plans and interRAI assessments, require further improvement. The remaining three areas of improvement from the previous audit, relating to medication management, building maintenance and the use of single use items, have all been addressed and are closed.

## 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.		Some subsections applicable to this service partially attained and of low risk.
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Residents and their whānau are informed of their rights including consent, according to the Code of Health and Disability Services Consumers' Rights (the Code) and these are upheld.

Personal identity, independence, privacy and dignity are respected and supported. Residents are safe from abuse and both personal property and finances are respected and protected within the scope of the facility. Residents and whānau receive information in an easy-to-understand format and feel listened to and included when making decisions about care and treatment. Open communication is practised. Interpreter services are provided as needed.

Whānau and legal representatives are involved in decision-making that complies with the law. Advance directives are followed wherever possible.

The service supports residents that identify as Māori and Pasifika and enacts Te Tiriti o Waitangi within its work at the facility.

Information on how to make a complaint is readily available and all concerns raised have been responded to promptly and in an appropriate manner.

## 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.		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 owners assume accountability for delivering a high-quality service. This includes ensuring compliance with legislative and contractual requirements, supporting quality and risk management systems, and reducing barriers to improve outcomes for Māori.

Planning ensures the purpose, values, direction, scope and goals for the organisation are defined. Performance is monitored and reviewed at planned intervals.

A clinical governance structure meets the needs of the service, supporting and monitoring good practice.

The quality and risk management systems are focused on improving service delivery and care using a risk-based approach. An integrated approach includes the collection of quality improvement data, with limited analysis undertaken to identify trends and improvements. Actual and potential risks are identified and mitigated.

The National Adverse Events Policy is followed, with corrective actions supporting systems learnings. The service complies with statutory and regulatory reporting obligations.

Staffing levels and skill mix meet the cultural and clinical needs of residents. Staff have the skills, attitudes, qualifications and experience to meet the needs of residents. A systematic approach to identify and deliver ongoing learning supports safe equitable service delivery.

Professional qualifications are validated prior to employment. Staff felt well supported through the orientation and induction programme with regular performance reviews implemented.

## Ngā huarahi ki te oranga | Pathways to wellbeing

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

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

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

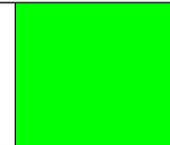
Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents, with special cultural needs and diets catered for. Food is safely managed.

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

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

Includes 2 subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.

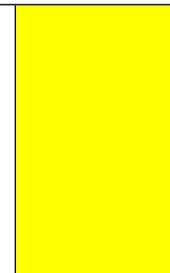


Subsections applicable to this service fully attained.

The facility, plant and equipment meet the needs of residents and were culturally inclusive. A current building warrant of fitness and planned maintenance programme ensures safety. Electrical equipment is tested as required.

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

Includes 5 subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.



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

The clinical manager who is the infection control coordinator ensures the safety of residents and staff through a planned infection prevention (IP) and antimicrobial stewardship (AMS) programme that is appropriate to the size and complexity of the service. The infection control coordinator reports monthly to senior management at the facility. The programme is adequately resourced. The training and IPC programme is relevant to the residents' care needs and clinical complexity. Staff were observed to carry out good IPC practices.

## Here taratahi | Restraint and seclusion

Includes 4 subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.

Subsections applicable to this service fully attained.

The service provides a restraint-free environment, supported by the owners, the leadership team and the facility's policies and procedures. There were no residents using restraints at the time of audit, which has been the case since last year.

Staff have been trained in providing the least restrictive practice, alternative interventions and demonstrated effective practice.

### 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	13	0	2	3	0	0
Criteria	0	45	0	3	4	0	0

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

# Attainment against the Ngā Paerewa Health and Disability Services Standard

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

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

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

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	FA	<p>Annaliese Haven has developed policies, procedures and processes to embed and enact Te Tiriti o Waitangi in all aspects of its service delivery. Staff and managers had completed training around Te Tiriti and cultural safety. Links have been established with Te Whatu Ora cultural advisors to support service integration, planning, equity approaches and support for Māori. A Māori health plan has been developed and is used for residents who identify as Māori, in consultation with the resident and their whānau. Manu motuhake is respected.</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</p>	FA	<p>Annaliese Haven has a Pacific health plan and ethnicity awareness policy that supports culturally safe practices for Pacific peoples using the service. Pacific people were being supported by the service, with ongoing planning and evaluation of services and outcomes, to ensure the equity of service delivery. Staff interviewed said they speak with Pasifika residents and their families to ensure that their cultural needs are being met, and also to confirm that their worldview, cultural and spiritual beliefs are being</p>

<p>equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.</p>		<p>embraced.</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>	<p>FA</p>	<p>The Code of Health and Disability Services Consumers' Rights (the Code) was available and displayed in English and te reo Māori throughout the facility, as was a range of signage in te reo Māori. Interviews with visitors, the GP and observation of interactions between staff and residents, confirmed staff are respectful and considerate of residents' rights in line with the Code.</p> <p>Observation and interviews with residents and family confirmed that residents are made aware of their rights and that this is explained on entry to the service and also during interactions between staff and residents.</p>
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	<p>FA</p>	<p>Family members and residents interviewed expressed satisfaction with the services provided by the facility. They reported that staff were respectful and that there was no evidence of abuse of any kind. Residents and family interviewed stated that they felt comfortable raising issues or concerns with management staff and that matters would be dealt with appropriately and professionally.</p> <p>Personal property and finances are respected and protected within the scope of the facility.</p> <p>Evidence was sighted both in the documentation review, such as care plans, and through observation, of the residents being treated respectfully and free of any kind of discrimination by staff. Professional boundaries were observed to be maintained by staff, and staff would knock and wait for a response before entering a resident's room.</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</p>	<p>FA</p>	<p>Residents and/or their legal representatives are provided with the information necessary to make informed decisions and to give consent in line with the Code. Residents and whānau interviewed felt empowered to actively participate in decision-making and they are provided with the</p>

<p>information that supports me to understand why.  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.  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>necessary information on which to base their decisions. The nursing and care staff observed understood the principles and practice of informed consent and of individual residents' preference in daily interactions.</p>
<p>Subsection 1.8: I have the right to complain  The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.  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.  As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>	<p>PA Low</p>	<p>A fair, transparent, and equitable system is in place to receive and resolve complaints that leads to improvements. The process meets the requirements of the Code. Residents and whānau understood their right to make a complaint and knew how to do so.</p> <p>Documentation sighted showed that complainants had been informed of findings following investigation. Where service improvements were identified as part of an investigation, these were implemented and discussed at staff meetings. A restraint register is maintained, which includes a record of the communications and documentation relating to each complaint.</p> <p>There have been two complaints that were received through external sources since the previous audit. Each one was investigated and records showed that feedback was provided to the complainant, or in the case of one anonymous complaint, the funder.</p> <p>The service does not include ethnicity data in their complaint management process and does not have processes to help ensure the complaint process works equitably for Māori. This is identified as an area of improvement and has been given a low risk due to the low number of complaints received and the low number of Māori residents supported by the service.</p>
<p>Subsection 2.1: Governance</p>	<p>FA</p>	<p>The owners as the governing body assume accountability for delivering a high-quality service to the residents who are living at the facility. One of</p>

<p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>		<p>the owners when interviewed, confirmed their knowledge and understanding of Te Tiriti, health equity and cultural safety, and has completed training on these topics.</p> <p>The leadership structure is appropriate to the size and complexity of the organisation and there is an experienced and suitably qualified facility manager and clinical manager managing the service.</p> <p>The purpose, values, direction, scope and goals are defined, and monitoring and reviewing of performance occurs through regular reporting at planned intervals. A focus on identifying barriers to access, improving outcomes, and achieving equity for Māori and tāngata whaikaha was evident. A commitment to the quality and risk management system was evident. The owner regularly visits the facility and is in frequent contact with the facility manager. When interviewed one of the owners said they were kept well informed on progress and risks.</p> <p>Compliance with legislative, contractual and regulatory requirements is overseen by the owners and facility manager, with guidance and advice provided through an external consultancy as required.</p> <p>People receiving services and their whānau participate in planning and evaluation of services through satisfaction surveys, and resident meetings.</p> <p>The service holds contracts with Te Whatu Ora – Health New Zealand Waitaha Canterbury (Te Whatu Ora Waitaha Canterbury) for rest home, respite, hospital level care, end-of-life care and dementia care. Fifty-seven residents were receiving services under the contracts on the day of the audit. This included twenty-nine residents receiving rest home level dementia care, and ten residents receiving rest home care, including one receiving respite care. There were eighteen residents receiving hospital level care, including one resident receiving end-of-life care and one resident receiving hospital level respite care.</p>
<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p>	<p>PA Moderate</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, policies and procedures, and</p>

<p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>		<p>clinical incidents including infections and falls. Residents and whānau contribute to quality improvement through annual satisfaction surveys and biannual food satisfaction surveys, which were viewed and indicate people are satisfied with the service being provided. Delivering high-quality care to Māori residents is supported through relevant training, tikanga policies, and access to cultural support roles internally and externally.</p> <p>The collection of clinical data is occurring, which is sorted and reported on. There was no evidence that ethnicity data is being included in the data collection or reporting to help identify possible inequities within the service. There is also no evidence that critical analysis of the clinical data is being done to help inform clinical practice and systems. This was identified as an area of improvement at the previous audit, and remains as an area for improvement, with an increased risk level and reduced time period.</p> <p>The quality framework includes an internal audit programme, which is completed as scheduled using a variety of audit tools. Any areas of improvement identified through the audits are addressed promptly. The quality framework does not include any quality outcomes that the service has identified and is working towards. Therefore, no evaluation of quality outcomes is being undertaken, which has been identified as an area of improvement.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements and were current.</p> <p>The facility manager described the processes for the identification, documentation, monitoring, review and reporting of risks, including health and safety risks, and development of mitigation strategies.</p> <p>Staff document adverse and near-miss events in line with the National Adverse Event Policy. A sample of incidents forms reviewed showed these were fully completed; incidents were investigated, action plans developed and actions followed up in a timely manner.</p> <p>The facility manager understood and has complied with essential notification reporting requirements.</p>
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<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	<p>PA Moderate</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. The staff roster is based on a two-week cycle, and a review of the roster showed that there is one RN rostered on 24/7 to provide the RN coverage across the facility, to meet contractual requirements. In addition, the CM who is a RN is also available during the day on weekdays. The review of the roster showed there was at least one staff member on duty with a current first aid certificate.</p> <p>Those providing care reported there were adequate staff to complete the work allocated to them. Residents and whānau interviewed supported this. The availability of staff was identified as an area of improvement at the previous audit and most of the issues raised have now been addressed. The exception relates to the activities programme, with the activities staff not employed to work on weekends or public holidays, and there is no structured programme in place for residents on weekends or after hours. Therefore, the previous area of improvement relating to criterion 2.3.1 remains open.</p> <p>The employment process, which includes a job description defining the skills, qualifications, and attributes for each role, ensures services are delivered to meet the needs of residents.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Related competencies are defined by policy, but not all staff had completed the competencies specific to their role, within the required period, which had been identified as an area of improvement. There is no process in place to track the completion of required training topics and the associated competencies.</p> <p>Once employed for three months, care staff are supported to commence a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with Te Whatu Ora Waitaha Canterbury. Staff working in the dementia care area have either completed or are enrolled in the required education.</p> <p>Staff reported feeling well supported and safe in the workplace.</p>
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<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. A sample of six staff records reviewed confirmed the organisation's policies are being consistently implemented. Job descriptions were documented for each role. Professional qualifications and registration (where applicable) had been validated prior to employment.</p> <p>Staff reported that the induction and orientation programme prepared them well for the role and evidence of this was seen in files reviewed. Opportunities to discuss and review performance occur three months following appointment and yearly thereafter, as confirmed in records reviewed.</p> <p>Staff information, including ethnicity data, is accurately recorded, held confidentially, and used in line with the Health Information Standards Organisation (HISO) requirements.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>PA Moderate</p>	<p>Six clinical files were reviewed including three using tracer methodology.</p> <p>A care plan is developed by an RN following an assessment, including consideration of the person's lived experience and their individual cultural needs, values, and beliefs. The care plan also considers wider service integration, such as physiotherapy, occupational therapy, or dietitian input, where required. Assessments are based on a range of clinical assessments and include resident and their family/whānau input. Documentation and assessments are stored in a secured electronic management system.</p> <p>Timeframes for the initial assessment, general practitioner (GP) input and initial care plan, met contractual requirements in the files reviewed. However, three of the files reviewed did not have the residents' long-term care plans reviewed within the required contractual timeframe. In addition, they were not aligned or integrated with the interRAI assessments. Further analysis of the files highlighted that a total of eight interRAI assessments and 12 long term care plans were overdue by up to five weeks. However, review of the six clinical files, appraisal of four further files, observation, and discussion with residents, GP and whānau did not</p>

		<p>highlight any areas of immediate clinical concern. Short-term care plans were instigated within an appropriate time frame and were followed and updated by care staff, and then closed or transferred onto the long-term care plan as required.</p> <p>A corrective action under 3.2.1 identified at the last certification audit was reviewed and there continued to be long-term care plans and interRAI assessments outstanding as highlighted above. This therefore remains a corrective action, although the timeframe required to resolve the issues has been significantly reduced so that they are addressed in a timely manner.</p> <p>The GP visits the facility for one morning each week. The GP spoke positively about the staff and the care provided to residents. Residents and whānau also stated that they were very happy with the care provided. After hours services based in Christchurch provide clinical support to the facility when the GP is unavailable. A Te Whatu Ora Waitaha Canterbury gerontology nurse specialist can also provide clinical advice when requested by the facility. If an ambulance is called, there is also the facility to discuss potential interventions with them and an on-call emergency department doctor.</p> <p>In the dementia wing, snacks and drinks were always available.</p>
<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>A safe system for medicine management using an electronic system was observed on the day of audit. The medication management policy is current and in line with the Medicines Care Guide for Residential Aged Care. Prescribing practices are in line with legislation, protocols, and guidelines. The required three-monthly reviews by the GP were recorded during the review of 12 medication charts on the facility's electronic medication management system.</p> <p>There is space for documenting residents' allergies and sensitivities on the medication chart and in the resident's record, and these were all completed appropriately in the charts reviewed. The service has policies and procedures on management of medication adverse events, and staff on the medication round demonstrated knowledge of these.</p> <p>A system is in place for returning expired or unwanted medication to the contracted pharmacy. The medication refrigerator temperatures are checked daily, and medication room temperatures were monitored weekly</p>

	<p>and were both seen to be consistently within the correct limits. Medications were stored securely in a locked room in accordance with requirements.</p> <p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of accurate entry and the required stock checks.</p> <p>Standing orders and verbal orders are not used.</p> <p>Residents that are self-administering medication have the correct assessments, documentation and processes in place, including regular review by the GP and the safe storage of their medications.</p> <p>The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines were competent to perform the function they manage; current medication competencies were evident in staff files. The RN oversees the use of all pro re nata (PRN) medicines and documentation regarding effectiveness was noted in progress notes. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy.</p> <p>Interviews with family members confirmed that changes to medications and the reasons for this are explained to residents or their EPOA as appropriate.</p> <p>A previous corrective action under 3.4.1 as a result of the last certification audit was reviewed during this audit. The corrective action had highlighted that not all elements of the medication management system met the required standard to enable safe administration of medications specifically with respect to labelling. During this audit, medications in the medication cabinets and medication trolleys were examined and all eye drops, personal medications, inhalers, and inhaler spacers were clearly named, dated and stored appropriately in line with the Medicines Care Guide for Residential Aged Care. This included the clear recording of the date of opening of eye drops and medications. The corrective actions for subsection 3.4.1 have now been fully achieved.</p>
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<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>An approved food control plan was sighted which expires on 16 January 2024. There is a winter and summer menu which has been reviewed by a dietitian, but personal and cultural preferences can be catered for on an individual basis when required.</p> <p>Residents' food preferences, allergies, intolerances and dietary needs are discussed and documented on admission to the facility and this information is recorded in the resident file and sent to the kitchen. Discussion with the head chef and observation confirmed that this information is displayed clearly in the kitchen so that all staff are aware of individual dietary needs, and food can be served to the residents accordingly.</p> <p>A corrective action under 3.5.4 from the previous certification audit was reviewed. This corrective action relates to ensuring the menu followed has been approved by a qualified dietitian. At this audit it was confirmed that menus are reviewed by a dietitian with the next review being due in December 2023. Recommendations following the last dietitian report on 29 October 2022 have been implemented. Discussion with the chef and review of the menu confirmed that if there are changes to the menu, it is with foods of a similar nutritional value, such as fresh vegetables when unavailable being replaced with vegetables of a similar type. The corrective actions for subsection 3.5.4 have now been fully achieved.</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>Transfer or discharge from the facility is planned and managed safely to cover current needs and to mitigate risk. The plan is developed with coordination between services and in collaboration with the resident and their family/whānau. This included the transfer of documentation, such as interRAI assessments and clinical information as appropriate, whilst maintaining resident confidentiality and privacy. A transfer document is used when transferring residents by ambulance to hospital. Whānau reported being kept well informed during the transfer of their relatives. Information provided includes falls risk, mobility and aids, continence, vision and hearing, as well as clinical presentation at the time of transfer.</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>FA</p>	<p>Appropriate systems are in place to ensure the physical environment and facilities (internal and external) are fit for their purpose, well maintained and that they meet legislative requirements.</p> <p>The environment was comfortable and accessible, promoting independence and safe mobility and minimising risk of harm. Personalised equipment was available for residents with disabilities to meet their needs. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility.</p> <p>Residents and whānau were happy with the environment, including heating and ventilation, natural light, privacy, and maintenance.</p> <p>At the previous certification audit a corrective action was identified under 4.1.2 due to a number of maintenance issues around the facility. These were reviewed during this audit and all areas had been addressed and the requirements of the corrective action have been fully achieved. In addition, there have been other refurbishment works undertaken to improve the physical environment, including recarpeting the facility, the purchase of new furniture and redeveloping outdoor areas, including decking replacement and outdoor canopy installations.</p> <p>The current environment is inclusive of people's cultures and supported cultural practices. No new buildings are planned, but the owner is aware of the requirement for consultation to ensure the design reflects the cultural needs and practices of Māori.</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>FA</p>	<p>The clinical manager is an experienced RN and is responsible for the oversight and implementation of the documented infection prevention and control (IPC) programme with reporting lines to the facility manager and facility owner. The IPC training programme is relevant to the residents' care needs and clinical complexity.</p> <p>The CM collates the monthly reports and the infection recording database was viewed with examples of the monthly IPC surveillance report. The CM receives support from the community and public health team and GP as</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>required.</p> <p>Staff training at orientation and yearly updates includes IPC, handwashing, and personal protective equipment (PPE) donning and doffing. Infection prevention updates are included in monthly staff team meetings. Staff were observed to carry out good IPC principles, with handwashing and sanitising in between residents on medication rounds and between residents' care provision. Additional education is provided to staff in the event of any outbreaks or increases in infections.</p> <p>A corrective action under 5.2.3 was identified at the last certification audit relating to the disposal of single use items and processes for the disinfection of reusable instruments. At this audit it was noted that there are written policies and procedures available to staff with respect to the use of single use items and the cleaning of reusable wound care instruments. Single use items were seen to be disposed of correctly by staff. The facility has an autoclave to steam sterilise reusable items and staff are instructed in its correct use. Regular audits are carried out to ensure the correct processes are followed with respect to sterilising equipment. The corrective actions for subsection 5.2.3 have now been fully achieved.</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>PA Low</p>	<p>IPC surveillance is appropriate to the size and complexity of the facility and the needs and acuity of its residents and the wider health system. Public health guidelines with respect to outbreaks and infections reported are followed. The surveillance data is recorded and reported on monthly, and it is reported to the FM and owners. In addition, IPC and infection data is reported to staff at monthly meetings or as required in the case of an outbreak. However, there is no evidence of monthly trend analysis or the recording of ethnicity data.</p>
<p>Subsection 6.1: A process of restraint</p>	<p>FA</p>	<p>Maintaining a restraint-free environment is the aim of the service. The owners demonstrated commitment to this and are supported by the CM</p>

<p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>		<p>who performs the role of restraint coordinator for the facility. At the time of audit there was no restraint used and this has been the case since last year. Any use of restraint is reported to the owners through the facility manager.</p> <p>Policies and procedures meet the requirements of the standards. Staff have been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques.</p> <p>The monthly heads of department/quality meetings have restraint as a regular agenda item. This group fulfils the function of the restraint approval group lead by the clinical manager in their role as the restraint coordinator for the facility. There were clear lines of accountability in place, regarding restraint approval monitoring, analysis and evaluation, should a restraint be required in future. Whānau/EPOA would be actively involved in decision-making around restraint use, monitoring and evaluation of use.</p>
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## Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our rights.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.8.5</p> <p>The Code of Health and Disability Services Consumers' Rights and the complaints process shall work equitably for Māori.</p>	PA Low	<p>From a review of complaint documentation, ethnicity information is not being captured as part of the complaint management process or included in the complaint register. Therefore, complaint information is not being analysed to evidence that the complaint process works equitably for Māori. There was no evidence of processes introduced to make the complaint process more accessible to Māori, for example, complaint forms available in te reo Māori, or having a cultural support person available.</p>	<p>There is a complaint process in place, but it does not include a system to ensure the complaints process works equitably for Māori.</p>	<p>Implement processes to monitor and evidence that the organisation's complaints process works equitably for Māori.</p> <p>180 days</p>
<p>Criterion 2.2.2</p> <p>Service providers shall develop and implement a</p>	PA Moderate	<p>There is basic reporting of clinical data, for example infections by type, with limited analysis of this data occurring.</p>	<p>There is reporting of clinical data, with limited analysis occurring, however no critical thinking or</p>	<p>Collect clinical data, inclusive of ethnicity data, and complete analysis of</p>

<p>quality management framework using a risk-based approach to improve service delivery and care.</p>		<p>There is no evidence of any critical thinking being done around the data that is gathered to help inform clinical practice. There is no evidence that the ethnicity of the residents is being included in the analysis of the clinical data. There is no benchmarking of clinical data with other similar facilities as an indicator of clinical practice, which is available through the electronic quality system used by the provider.</p>	<p>benchmarking is being completed to help inform clinical practice.</p>	<p>this information involving critical thinking and benchmarking to inform clinical practice.</p> <p>60 days</p>
<p>Criterion 2.2.3 Service providers shall evaluate progress against quality outcomes.</p>	<p>PA Moderate</p>	<p>The review of the quality framework and the quality meeting minutes showed no evidence that any quality outcomes had been identified and set for the facility to work on. With no quality outcomes set, this meant it was not possible to evaluate any progress made to show any improvement.</p>	<p>The quality framework does not include defined quality outcomes that are being worked towards and therefore quality outcomes are not being evaluated as required by the standard.</p>	<p>As part of the facility's quality framework, identify and set quality outcomes for the facility to work towards, and evaluate progress against these outcomes on a regular basis.</p> <p>90 days</p>
<p>Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.</p>	<p>PA Moderate</p>	<p>From the review of the roster, one diversional therapist is employed during the week to lead the activity program for the facility and is supported by an activities coordinator each weekday. There are no activities staff employed at the weekend or on public holidays to coordinate activities for residents. A review of the weekly activity plan shows that there are no planned activities for residents on the weekends or on public holidays, which was also confirmed by staff at interview. The facility has an</p>	<p>The review of staffing levels show that sufficient healthcare and support workers are on duty to provide safe services. The activity staff are employed to provide activities on weekdays, with no structured activity programme available on the weekends, or after hours in the dementia unit.</p>	<p>Implement an activity program that includes activities for residents during the weekend days and includes activities that are available for residents in the dementia unit 24/7.</p> <p>90 days</p>

		activities cupboard in both the rest home and dementia unit with the view that residents can access activities if they want to. In the dementia unit self-help activities were placed into pockets on the wall, but these were pulled apart by the residents, so no activities are available to these residents after hours.		
<p>Criterion 2.3.3</p> <p>Service providers shall implement systems to determine and develop the competencies of health care and support workers to meet the needs of people equitably.</p>	PA Low	From the review of staff files and competency records, not all staff had completed the required competencies specific to their role. The training policy outlines the competencies each role needs to complete, including the frequency that the competency needs to be done, with most competencies required to be annually, or biennially. In addition, there was no process in place to easily track the competencies each employee was required to complete, who had completed each competency, and when these were due to be redone.	Not all staff had completed the required competencies as outlined and defined in the organisation's training policy.	<p>Ensure all staff have completed the required competencies specific to their role, and within the specified timeframes, as outlined in the organisation's training policy.</p> <p>180 days</p>
<p>Criterion 3.2.1</p> <p>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.</p>	PA Moderate	Review of the files highlighted that a total of eight interRAI assessments and 12 long term care plans were overdue by up to five weeks.	Individual care or support plans have not been completed within the required contractual timeframe	<p>All resident's interRAI assessments and all long-term care plans to be completed within the facility's required contractual timeframe.</p> <p>30 days</p>

<p>Criterion 5.4.3</p> <p>Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.</p>	<p>PA Low</p>	<p>There was no evidence of concerning levels or trends in infection rates such as urinary tract infections, cellulitis or Covid –19, and any infections that did occur were managed appropriately. Any interventions were in line with current guidelines. IPC surveillance and analysis is collected and reported monthly, but there was no evidence of trend analysis over longer time periods, such as comparing urinary tract infection numbers over a six-month period. There was no evidence of the recording of ethnicity data.</p>	<p>Surveillance records are incomplete as there is no evidence of either trend analysis or of ethnicity data.</p>	<p>Provide monthly trend analysis of infection rates that includes ethnicity data.</p> <p>180 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

As above, criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

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End of the report.