

The Willows Home and Hospital Limited - The Willows Home and Hospital

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 Manatū Hauora (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 Manatū Hauora website by clicking [here](#).

The specifics of this audit included:

| | |
|---|--|
| Legal entity: | The Willows Home and Hospital Limited |
| Premises audited: | The Willows Home and Hospital |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 10 April 2024 End date: 10 April 2024 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 23 |



Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou 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

The Willows Home and Hospital Limited - The Willows Home and Hospital provides rest home and hospital level care for up to 28 residents. There have been no changes since the last audit with the exception that there are now five residents receiving care under contract with Whaikaha (Ministry of Disabled People) at hospital level care, as well as three other residents under the age of 65 years of age.

This surveillance audit was conducted against the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 and the provider's contract with Te Whatu Ora – Te Toka Tumai Auckland. The process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, whānau/family members, the owner, staff, and a general practitioner.

At the last audit there were 11 areas identified as requiring improvement. The aspects related to identifying Māori residents' cultural needs in the care plan, infection surveillance data, staffing, declining entry to services process, medication reconciliation and monitoring effectiveness of 'pro re nata' medication, signage and consent processes alerting that security cameras in use, and laundry practices, have been addressed. The recommendation to include equity in risk management processes has also been addressed.

Five areas remain requiring improvement and these include the detail recorded in staff meeting minutes, resident meetings, and corrective action planning, with evaluation of incident-related themes and trends now added. InterRAI assessments, and care planning continue to require improvement and now include additional areas requiring improvement related to ensuring cultural

needs of Pasifika residents are clearly documented, diet profiles reviewed, neurological monitoring of residents post unwitnessed fall, maintaining turning records for bedridden residents, and all aspects of assessment, consent, monitoring and review when residents have restraints in use. Individualised activities programmes have not yet been implemented.

As a result of this audit, nine new areas for improvement are identified related to: providing services within the scope of certification, essential notification, staff competency, ongoing education, staff orientation and records management, expired medications/monitoring the ambient temperature of the medication room, annual review of the infection control programme, and two areas related to restraint.

Ō tātou 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 are fully attained. |
|---|--|--|

The Willows Home and Hospital 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 the principles of mana Motuhake.

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

Staff understand the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code). The service has a policy on abuse and neglect, including what to do should there be any signs of such. The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of conduct. Residents' property and finances are respected, and professional boundaries are maintained. Staff are guided by the code of conduct to ensure the environment is safe and free from any form of institutional and/or systemic racism. Informed consent for specific procedures is gained appropriately.

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

Hunga mahi me te hanganga | Workforce and structure

| | | |
|--|--|---|
| <p>Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.</p> | | <p>Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.</p> |
|--|--|---|

The owner assumes 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. The owner has owned this care home since 2019 and is supported by a nurse manager who is responsible for clinical governance processes.

The quality and risk management framework has a continuous improvement focus. Actual and potential risks are identified and mitigated. Incidents and adverse events are reported and investigated.

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.

Professional qualifications are validated prior to employment and are monitored to ensure they are current for employed and contracted registered health professionals. Staff are provided with an orientation. Regular performance reviews occur.

Ngā huarahi ki te oranga | Pathways to wellbeing

| | | |
|--|--|---|
| <p>Includes eight 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.</p> | | <p>Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.</p> |
|--|--|---|

Residents are assessed before entry to the service to confirm the level of care required. The nurse manager (NM) is responsible for the assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs and routines. Interventions are developed and implemented.

There is a medicine management system in place. All medications are reviewed by the general practitioner (GP) every three months. Policies and procedures require staff to have current medication competencies.

The food service provides for specific dietary likes and dislikes of the residents. Nutritional requirements are met.

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

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

| | | |
|--|--|---|
| <p>Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.</p> | | <p>Subsections applicable to this service are fully attained.</p> |
|--|--|---|

The facility, plant and equipment meet the needs of residents and are culturally inclusive. The building has a current building warrant of fitness. Electrical equipment is tested as required. Signs alert that security cameras are in use. There have been no changes to the approved fire evacuation plan in place at the last audit.

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

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

The service ensures the safety of the residents and of staff through a planned infection prevention (IP) and antimicrobial stewardship (AMS) programme that is appropriate to the size and complexity of the service. The owner coordinates the programme.

Orientation and ongoing education of staff is maintained. There were sufficient infection prevention resources, including personal protective equipment (PPE), available and readily accessible to support the plan if it is activated.

Surveillance of health care-associated infections is undertaken, and results are shared with all staff. Follow-up action is taken as and when required. All infection outbreaks are managed according to Ministry of Health (MoH) guidelines.

Here taratahi | Restraint and seclusion

| | | |
|---|--|--|
| Includes four 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 are partially attained and of medium or high risk and/or unattained and of low risk. |
|---|--|--|

The service has a restraint-free philosophy as detailed in policy. There were residents using restraints at the time of audit.

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 | 3 | 6 | 0 | 0 |
| Criteria | 0 | 40 | 0 | 4 | 10 | 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

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.

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>The Willows Home and Hospital has developed policies, procedures and processes to embed and enact Te Tiriti o Waitangi in all aspects of its work. Mana motuhake is respected. Partnerships have been established with whānau and Māori organisations as appropriate to support service integration, planning, equity approaches, and support for Māori. There were Māori residents at the time of audit, and those interviewed felt culturally safe.</p> <p>Te Whare Tapa Whā model of care is used in the development of care plans for residents that identify as Māori. The shortfall from the last audit has been addressed.</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</p> | FA | <p>The Willows Home and Hospital provides services that are underpinned by Pacific worldviews. Pasifika residents interviewed felt their worldview, and cultural and spiritual beliefs were embraced. Pacific models of care have not been used in the development of Pasifika residents' care plans. This is raised as an area for improvement in criterion 3.2.5.</p> |

| | | |
|--|-----------|--|
| <p>and developed in collaboration with Pacific peoples for improved health 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> | <p>FA</p> | <p>All staff interviewed at the service understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents to follow their wishes. Training on the Code has not been completed for staff (refer to 2.3.4). 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.</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>All staff understood the service's policy on abuse and neglect, including what to do should there be any signs of such. The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of conduct. A code of conduct statement is included in the staff employment agreement. The owner/manager reported that education on abuse and neglect is provided as required. Residents reported that their property and finances were respected and that professional boundaries were maintained.</p> <p>The owner/manager reported that staff are guided by the code of conduct to ensure the environment is safe and free from any form of institutional and/or systemic racism. Whānau 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.</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</p> | <p>FA</p> | <p>Signed admission agreements were evidenced in the sampled residents' records. Informed consent for specific procedures had been gained appropriately. The consent process now includes that</p> |

| | | |
|--|------------------------|---|
| <p>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>there are security cameras in use. Resuscitation and service plans were signed by residents who were competent and able to consent, and a medical decision was made by the general practitioner (GP) for residents who were unable to provide consent. Interviews with residents and relatives confirmed the service actively involves them in decisions that have to do with their daily care.</p> |
| <p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p> <p>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p> | <p>FA</p> | <p>A fair, transparent, and equitable system is in place to receive and resolve complaints that leads to improvements. The process meets the requirements of the Code. Residents and whānau understood their right to make a complaint and knew how to do so. No complaints were raised at audit. Information on the complaints process is included in the new resident 'welcome pack'.</p> <p>Documentation sighted showed that complainants had been informed of findings following investigation.</p> <p>The service assures the process works equitably for Māori by involving whānau in discussions if the complainant wants this. Independent advocacy would be facilitated, and cultural supports obtained if wanted by the complainant.</p> <p>There have been two complaints received from the Health and Disability Commission (HDC) since the previous audit. The service has responded to the complaints and provided the information requested and is awaiting HDC response.</p> |
| <p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> | <p>PA Moderate</p> | <p>The owner (who is also the facility manager) assumes accountability for delivering a high-quality service to users of the services and their whānau. The owner has been working in aged care for approximately 47 years and has owned The Willows Home and Hospital since 1999. The owner has not attended eight hours of education related to</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>managing an aged residential care service in the last 12 months. This is included in the area for improvement raised in criterion 2.3.4.</p> <p>Compliance with legislative, contractual and regulatory requirements is facilitated with the assistance of an external quality facilitator who provides The Willows Home and Hospital (TWHH) with updated policies and procedures as legislative or other sector changes occur. The owner confirmed that not all essential notifications have occurred as required. This is raised as an area for improvement. The service does not have residential physical disability included in the scope of certified services.</p> <p>The nurse manager was in the role at the last audit and was on leave during this unannounced surveillance audit.</p> <p>The purpose, values, direction, scope and goals are defined, and monitoring and reviewing of performance occurs through regular reporting at planned intervals. An annual business plan was in place for 2024. A focus on identifying barriers to access, improving outcomes, and achieving equity for Māori was evident in plans and monitoring documentation reviewed, and through admission processes. The owner interviewed felt well informed on quality and risks, although had misunderstood what restraint is (refer to area for improvement raised in criteria 3.2.5 and 6.1.1). The owner is on site most days and works alongside the nurse manager.</p> <p>The clinical governance structure is appropriate to the size and complexity of the organisation, with the regular staff meeting being the forum where quality and risk is discussed.</p> <p>There were 23 residents receiving care at audit. The service holds age-related residential care (ARRC) contracts with Te Whatu Ora for rest home, hospital, and long-term conditions-chronic health conditions (LTC-CHC). There were eight residents receiving ARRC hospital level care and three at rest home level of care. There were two residents under LTC-CHC at hospital level of care and four at rest home level of care (including three residents under the age of 65 years).</p> <p>There is a contract with Accident Compensation Corporation for residential care at low and medium needs. There was one resident receiving services under this contract at medium needs. There is a</p> |
|---|--|

| | | |
|---|------------------------|--|
| | | <p>contract with Whaikaha for non-age-related residential care. There were five residents receiving services under this contract at hospital level care.</p> <p>There are no boarders.</p> |
| <p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p> | <p>PA Moderate</p> | <p>The organisation has a planned quality and risk system with a stated aim of continuous quality improvement.</p> <p>Policies reviewed covered all necessary aspects of the service and of contractual requirements and were current.</p> <p>The owner described the processes for the identification, documentation, monitoring, review and reporting of risks, including health and safety risks, and development of mitigation strategies. The recommendation from the last audit has been addressed. Work has been undertaken to mitigate registered nurse (RN) staffing related risks.</p> <p>Restraints are in use but are incorrectly reported via the quality and risk system as not being used. This is included in the area for improvement in criterion 6.1.1.</p> <p>Staff document adverse and near-miss events. The incident management policy has been updated in line with the National Adverse Events Reporting Policy. A sample of incidents forms reviewed showed these were fully completed and actions taken in response to individual events. Neurological observations are not consistently occurring post unwitnessed resident falls. This is included in the area for improvement raised in 3.2.5.</p> <p>There is limited analysis of incident-related events, themes and trends or discussion in staff meeting minutes. System improvements are not clearly identified where applicable. Internal audits are being undertaken; however, the actions required are not clearly included in the minutes of staff meetings. While resident meetings are now occurring, there is not a consistent framework/agenda for these meetings to ensure consistency of content. The two areas identified as requiring improvement at the last audit remain open. However, infection data is being reported and is legible and clear. This shortfall</p> |

| | | |
|---|------------------------|---|
| | | <p>from the last audit now meets the standards.</p> <p>The owner/manager understood the type of events that have required essential notifications. However, not all applicable events have been reported. This is an area requiring improvement.</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. 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. 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. Additional staff have been placed on the afternoon roster since the last audit. The shortfall raised at the last audit has been addressed.</p> <p>There is a registered nurse on duty in the current and future rosters sighted due to very recent events. However, this has not always been the case including most recently for 12 shifts in March 2024. These events were not reported as an essential notification and this is raised as an area for improvement in 2.2.6.</p> <p>The nurse manager has interRAI competency.</p> <p>Those providing care reported there were adequate staff to complete the work allocated to them. Residents and whānau interviewed supported this. At least one staff member on duty has a current first aid certificate. The general practitioner interviewed advised being on call when not on site and noted being happy with the clinical care provided to residents.</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>The nurse manager was away at audit and the owner provided what staff training/education records were able to be located. In the records sighted there was infrequent education occurring and not all topics included as per ARRC contract requirements. Staff competency records for new staff were sighted but were unable to be located for most staff. The manager has not attended eight hours of education related to managing an age-related residential care service</p> |

| | | |
|--|---------------|---|
| | | <p>in the last 12 months.</p> <p>The residents and whānau have regular input into care planning and evaluation processes. The owner has an open-door policy and is available to speak to residents and whānau at any time. This was observed. Resident meetings are also a forum where residents can make suggestions about topics of interest to them.</p> <p>Care staff are encouraged to complete a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the Te Whatu Ora – Te Toka Tumai Auckland. This was discussed with staff in the January 2024 staff meeting. All three-care staff interviewed have a level four qualification, including a staff member employed for approximately 12 months.</p> |
| <p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p> | <p>PA Low</p> | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented, including evidence of qualifications and registration (where applicable).</p> <p>Staff reported that the induction and orientation programme prepared them well for the role. Records of completion were not present in all applicable staff files sampled and this is required. Opportunities to discuss and review performance occur three months following appointment and yearly thereafter, as confirmed in records reviewed. There is a register of when staff appraisals are next due.</p> |
| <p>Subsection 3.1: Entry and declining entry</p> <p>The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p> | <p>FA</p> | <p>The previous area requiring improvement relating to the service having a documented clear process for communicating the decisions for declining entry to the service has been addressed. There is an entry and decline policy in place. All entry and declines are documented on the pre-inquiry form. The owner/manager reported that the entry and decline process is guided by the policies and procedures in place.</p> |

| | | |
|--|------------------------|--|
| <p>As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.</p> | | |
| <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>A total of five files were reviewed. All long-term care plans were evaluated addressing the previous area requiring improvement. The Needs Assessment and Service Coordination (NASC) agency confirmed the levels of care were completed and sighted in all files reviewed. Residents' files sampled identified that initial assessments and initial care plans were resident-centred, and these were completed in a timely manner. The service uses assessment tools that include consideration of residents' lived experiences, cultural needs, values, and beliefs. Nursing care is undertaken by appropriately trained and skilled staff, including the nursing team and care staff. Cultural assessments were completed by the nursing team in consultation with the residents, and family/whānau/Enduring Power Of Attorney (EPOA). However, Pasifika residents did not have a Pacific health plan in place. The previous area requiring improvement around developing Māori health care plans for residents who identify as Māori has been addressed. Residents who identify as Māori had a Māori health care plan in place addressing their cultural needs.</p> <p>The previous area requiring improvement around completing interRAI assessments, identifying outcome scores, and using them to support care plan goals and interventions remains open. InterRAI assessments in the database could not be verified that they were current as the nurse manager with competency was away on leave. Two of the five resident files reviewed had no interRAI assessments completed. Outcome scores from interRAI assessments were not identified on long-term care plans during regular reviews and detailed interventions developed. These included outcome scores such as falls, nutrition, restraint, and behavioural risks. Residents who were bed-bound had turning charts developed; however, monitoring was not consistently completed as per policy requirements. Nutritional profiles were not being updated six-monthly along with interRAI and</p> |

| | |
|--|--|
| | <p>care plan reviews. Neurological monitoring of residents post unwitnessed falls was not occurring as required by policy. Two residents were using bed rails as restraint; however, there was no assessment, consent, and monitoring completed. Please also refer to criterion 6.1.1.</p> <p>Resident, family/whānau/EPOA, and GP involvement is encouraged in the plan of care. The general practitioner (GP) completes the residents' medical admission within the required timeframes and conducts medical reviews promptly. Completed medical records were sighted in all files sampled. The GP reported that communication was conducted in a transparent manner, medical input was sought in a timely manner, medical orders were followed, and care was resident centred. Residents' files sampled identified service integration with other members of the health team. Multidisciplinary team (MDT) meetings were completed.</p> <p>The registered nurse on duty and owner/manager reported that sufficient and appropriate information is shared between the staff at each handover. Interviewed staff stated that they were updated daily regarding each resident's condition. Progress notes were completed on every shift and more often if there were any changes in a resident's condition. Short-term care plans were developed for short-term problems or in the event of any significant change, with appropriate interventions formulated to guide staff. The plans were reviewed weekly or earlier if clinically indicated by the degree of risk noted during the assessment process. These were added to the long-term care plan if the condition did not resolve in three weeks. Any change in condition was reported to the registered nurse or nurse manager; this was evidenced in the records sampled. This addresses the previous corrective action. Interviews verified residents and EPOA/whānau/family are included and informed of all changes.</p> <p>The care planning process ensured that young people with disabilities (YPD) have a plan in place that addresses their special needs, with the primary goal of increasing access, participation, and integration into the community. Strategies to support, maintain, and strengthen relationships with family/whānau and advocates were documented, including development and learning support to encourage residents' interests.</p> |
|--|--|

| | | |
|--|----------------|--|
| | | A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs. The EPOA/whānau/family and residents interviewed confirmed their involvement in the evaluation of progress and any resulting changes. |
| <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> | PA Moderate | Activities are conducted by the activity's coordinator. There were no activities assessments nor care plans that were individualised. An activities programme was not verified on the audit day. This corrective action remains open. |
| <p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and 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> | PA Low | <p>The medication management policy is current and in line with the Medicines Care Guide for Residential Aged Care. Medications are supplied to the facility from a contracted pharmacy. The GP completes three-monthly medication reviews. Indications for use were noted for pro re nata (PRN) medications. Allergies were indicated, and all photos uploaded on the electronic medication management system were current. Eye drops were dated on opening. Effectiveness of PRN medication was consistently documented, and medication reconciliation was completed and noted on the electronic medicine management system. Evidence of this was sighted. This addresses all previous areas requiring improvement.</p> <p>Medication competencies for all staff administering medicines were not current. This is included in the area for improvement raised in criterion 2.3.3). Medication incidents were completed in the event of a medication error and corrective actions were acted upon. A sample of these was reviewed during the audit.</p> <p>Inspection of medication procedures and onsite review of the medication round indicated the service follows approved protocols in administering. Medications were stored safely and securely in the trolley, locked treatment room, and cupboards. There were expired</p> |

| | | |
|---|----|--|
| | | <p>PRN medicines in the medication trolley and cupboard. Weekly and six-monthly controlled drug stocktakes were completed as required. Monitoring of the medicine fridge was conducted regularly; however, monitoring of the ambient temperature of the medication room was not occurring.</p> <p>Appropriate processes were in place to ensure residents who wish to self-administer medicine, including young people with disabilities, would be managed safely when required. There were no residents who were self-administering medicine at the time of the audit. There is a self-administration policy in place if required. There were no standing orders in use.</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> | FA | <p>The kitchen service complies with current food safety legislation and guidelines. All food and baking were being prepared and cooked on site. There was an approved food control plan in place.</p> <p>Diets were modified as required and the kitchen staff confirmed awareness of the dietary needs of the residents. Residents were given the option of choosing a menu they prefer. Residents have a nutrition profile developed on admission which identifies dietary requirements, likes, and dislikes; however, these were not updated six-monthly as required (refer to criterion 3.2.5). All alternatives are catered for as required. Snacks and drinks are available for residents throughout the day and night when required.</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</p> | FA | <p>Records sampled evidenced that the transfer and discharge planning included risk mitigation and current residents' needs. The discharge plan sampled confirmed that, where required, a referral to other allied health providers to ensure the safety of the resident was completed.</p> |

| | | |
|--|---------------|--|
| <p>coordinate a supported transition of care or support.</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>Building, plant and equipment are fit for purpose, inclusive of peoples' cultures and comply with relevant legislation. This includes a current building warrant of fitness and electrical and bio-medical testing.</p> <p>Residents and whānau were happy with the environment, including heating and ventilation, natural light, privacy, and maintenance.</p> |
| <p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p> | <p>FA</p> | <p>There have been no changes to the building since the previous audit. Staff attend six monthly fire safety training.</p> <p>Signage now alerts visitors that security cameras are in use. This is also discussed during admission processes and included in the resident and whānau consent. The shortfall from the last audit has been addressed.</p> |
| <p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p> | <p>PA Low</p> | <p>The service has a clearly defined and documented infection prevention and control (IPC) programme implemented that was developed with input from external IPC services. This has not been reviewed annually as per standard requirements.</p> <p>Staff have received education in IPC at orientation and through ongoing annual online education sessions. Additional staff education has been provided in response to the COVID-19 pandemic.</p> <p>Education with residents was 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</p> |

| | | |
|--|----|---|
| | | confirmed in interviews with residents. |
| <p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p> | FA | <p>The infection surveillance programme is appropriate for the size and complexity of the service. Infection data is collected, monitored, and reviewed monthly. The data, which includes ethnicity data, is collated and action plans are implemented. The health care-associated infections (HAIs) being monitored included infections of the urinary tract, skin, eyes, respiratory, and wounds. Surveillance tools are used to collect infection data and standardised surveillance definitions are used. All infection data is reported to the management.</p> <p>Infection prevention audits were completed including cleaning, laundry, personal protective equipment (PPE), donning and doffing PPE, and hand hygiene. It was unclear if relevant corrective actions were not implemented as required. This links with the areas requiring improvement raised in criteria 2.2.2 and 2.2.3).</p> <p>Staff reported that they are informed of infection rates and regular audit outcomes at staff meetings, and these were sighted in meeting minutes. 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. Benchmarking is completed using the previous month's results.</p> <p>There were no infection outbreaks reported since the previous audit.</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> | FA | <p>The laundry services are appropriate to the size and scope of the facility. Documented laundry processes are in place and staff are aware of any risk of cross-infection during their day-to-day delivery of care. Staff were observed disposing personal protective equipment properly. This addresses the previous area requiring improvement.</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>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p> | <p>PA Moderate</p> | <p>Organisation policy has a commitment to eliminating the use of restraint. However, at governance and operational level restraints are being used. The owner understood if restraints were being used for safety purposes this was not considered as restraint. Staff meeting minutes incorrectly note restraint is not in use and elimination of restraint has been achieved.</p> <p>Residents had restraints in use that did not have consent, assessment, and monitoring processes in place. This is included in the area for improvement raised in criterion 3.2.5.</p> <p>While staff could detail what restraint is, the staff training records available identified training on restraint, de-escalation and managing challenging behaviours was last completed in 2019. This requires improvement.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|--|---------------------------|---|---|---|
| <p>Criterion 2.1.1</p> <p>Governance bodies shall ensure compliance with legislative, contractual, and regulatory requirements with demonstrated commitment to international conventions ratified by the New Zealand government.</p> | <p>PA</p> <p>Moderate</p> | <p>Compliance with legislative, contractual and regulatory requirements is facilitated with the assistance of an external quality facilitator who provides The Willows Home and Hospital (TWHH) with updated policies and procedures as legislative or other sector changes occur. Information is also communicated as part of aged care networks and the nurse manager’s networks. The owner confirmed that not all essential notifications have occurred as required. This is raised as an area for improvement in criterion 2.2.6.</p> <p>The service has five or more residents under the age of 65 years and does not have</p> | <p>The service has five or more residents under the age of 65 years and does not have residential physical disability included in the scope of certification.</p> | <p>Apply to HealthCERT to have physical disability included in the scope of certification.</p> <p>30 days</p> |

| | | | | |
|--|------------------------|--|--|---|
| | | residential physical disability included in the scope of certification. | | |
| <p>Criterion 2.2.2</p> <p>Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.</p> | <p>PA Moderate</p> | <p>The quality and risk programme includes the reporting and management of incidents and complaints, internal audit activities, a resident satisfaction survey, having policies and procedures available to guide staff practice, and monitoring infections.</p> <p>Regular staff meetings are the forum where quality and risk topics are discussed. The infection data is now legible and understandable. The discussions related to completed internal audits just notes that the audits topic was completed and did not provide any information on the results, in particular where improvements are required this is not noted/discussed.</p> <p>Resident meetings are occurring monthly; however, an agenda or template is not used to facilitate discussions on a variety of relevant topics. Where residents have made requests at the meeting, there is no evidence the request has been addressed.</p> | <p>The staff meeting minutes do not show sufficiently detailed discussion on quality and risk activities and results of internal audits.</p> <p>Resident meetings do not have a template agenda or list of discussion topics to be covered at each meeting for consistency. There is no evidence of follow-up to documented resident requests.</p> | <p>Ensure the minutes of staff meetings are sufficiently detailed to inform staff on the outcomes from the quality and risk monitoring programme and actions required.</p> <p>Develop and implement a consistent agenda or minute template for resident meetings and ensure there is evidence of action taken in response to applicable resident requests.</p> <p>90 days</p> |

| | | | | |
|---|------------------------|--|--|---|
| <p>Criterion 2.2.3</p> <p>Service providers shall evaluate progress against quality outcomes.</p> | <p>PA Moderate</p> | <p>There are incidents, accidents, near miss events and resident infections that are being reported on and evaluated monthly. However, the evaluation is not sufficiently detailed related to incidents/adverse events. It notes the total number of events and the number and type of events. There is no analysis on whether the incident data, for example, falls, relate to one or more residents having multiple falls, or more residents falling but less frequently. There was no analysis of the time of day or what the resident was attempting to do when resident falls occurred. While individual incidents were investigated and responded to, there was no evidence wider systems-focused prevention factors have been identified and implemented. There is limited analysis of incident-related themes and trends.</p> <p>Internal audits are undertaken; however, the required improvements are not always noted or have been followed up. This links with subsection 5.4.</p> | <p>Incident/quality outcomes and internal audits are not sufficiently evaluated, and system improvements/corrective actions identified, implemented, monitored and reviewed for effectiveness.</p> <p>There is inadequate analysis of incident-related information, including themes and trends.</p> | <p>Ensure adverse events/incidents are sufficiently evaluated to identify themes, trends and systems improvements/corrective actions.</p> <p>Ensure corrective actions are consistently identified following internal audits, implemented and monitored for effectiveness.</p> <p>90 days</p> |
| <p>Criterion 2.2.6</p> <p>Service providers shall understand and comply</p> | <p>PA Moderate</p> | <p>The owner was able to detail the type of events that require essential notification as these</p> | <p>Not all section 31 notifications have occurred to relevant authorities as required.</p> | <p>Ensure all applicable events are reported to relevant authorities and agencies in a timely manner and records are retained to</p> |

| | | | | |
|---|--|---|--|---|
| <p>with statutory and regulatory obligations in relation to essential notification reporting.</p> | | <p>were discussed at audit.</p> <p>There have been multiple occasions in 2023 and some in early 2024 where there was not a registered nurse on duty at all times as required to meet the provider's contract with Te Whatu Ora – Health New Zealand. The owner was not able to provide quantifiable information related to the frequency this occurred without searching through payroll data, but noted this was not a rare occurrence during some months in 2023. There were 12 shifts in the roster 11 March 2024 to 31 March 2024 where there was not a RN on duty. The owner confirmed they had not informed the portfolio manager at Health New Zealand about this nor were section 31 notifications made.</p> <p>The owner stated they have used a third-year nursing student or a level four health care assistant on duty with the nurse manager and/or owner on call to cover these shifts. This links with information in subsection 2.3.</p> <p>The owner thought that the death of a resident in acute care services in late 2022 was reported to the coroner. However, the owner was not fully certain of this as stated had not been informed at the time. This information had been 'flagged' in June 2023 as a</p> | | <p>demonstrate this process.</p> <p>30 days</p> |
|---|--|---|--|---|

| | | | | |
|---|------------------------|---|--|---|
| | | <p>result of an external complaint. The owner stated they have never been contacted or asked to provide any information to the coroner. The owner is unsure if this event was reported as a section 31.</p> | | |
| <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> | <p>PA Moderate</p> | <p>There is a staff competency programme available that includes a range of competencies staff are required to complete. This includes use of hoist, first aid certification (for specified staff), restraint competency, fire safety, and cultural competency including equity.</p> <p>Some staff competencies were able to be located at audit. The owner stated that more had been done; however, they could not locate the records that are maintained by the nurse manager and the information was not in applicable staff files sampled. Staff interviewed confirmed there is a competency programme and a medication competency completed before being able to administer residents' medications and hoist competency before using the hoists, with ongoing competencies completed annually.</p> <p>The competency records sighted included medication</p> | <p>Records are not available to demonstrate that all staff have current competencies as required by organisation policy including medication competency.</p> | <p>Ensure all staff have current competencies as relevant to their role, responsibilities and in accordance with organisation policy. Ensure records are available to demonstrate staff achievement.</p> <p>90 days</p> |

| | | | | |
|--|---------------------------|---|---|--|
| | | competencies for two new RNs and one HCA (done in April 2024), first aid certification records (12 staff did the most recent training in July 2023), four staff have completed hoist competencies (between 22 January 2024 and 3 April 2024), and five staff have completed the fire safety questionnaire since November 2023. | | |
| <p>Criterion 2.3.4</p> <p>Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.</p> | <p>PA</p> <p>Moderate</p> | <p>A current staff education calendar or programme for 2023 and 2024 could not be located.</p> <p>In the education records available, four in-service education sessions were provided to staff in 2023 and included fire safety/evacuation (February and September 2023), first aid certification (July 2023), moving and handling (July 2023) and observation and reporting (February 2023). The September education also included information on aging. Records of attendance were sighted. In the records provided, training on the Code last occurred in July 2020, falls prevention and management (2019), and pressure injury management (April 2021). Not all topics required to meet ARRC contract requirements were included in the last two years in the records sighted. This links with the area for improvement</p> | <p>1.A staff training plan for 2023 and 2024 could not be located.</p> <p>2.Records are not available to demonstrate that staff have access to regular ongoing education that includes all topics to align with Ngā Paerewa standards and the age-related residential care contract.</p> <p>3.The owner has not attended eight hours of education related to managing an agreed related residential care service in the last 12 months.</p> | <p>1.Develop a training plan/calendar for 2024.</p> <p>2.Ensure there is an education programme in place that provides staff with regular ongoing education opportunities to meet Ngā Paerewa standards and the age-related residential care contract requirements.</p> <p>3.Ensure the owner (manager) attends at least eight hours of education related to managing an age-related residential care service annually.</p> <p>60 days</p> |

| | | | | |
|--|--------|---|---|--|
| | | <p>raised in criterion 6.1.6.</p> <p>The owner advised there was some disruption to the training programme due to the Covid-19 pandemic, so not all planned education occurred. The owner also advised that more education may have occurred than the records provided during audit as the nurse manager also provided staff with links to e-training modules run by an external provider. The owner did not have information of the topics, dates or the names of staff that have completed any e-learning modules. The November 2023 staff meeting minutes noted documentation and diet were education topics for the month.</p> <p>The owner has not attended eight hours of education related to managing an aged related residential care service in the last 12 months, as verified during interview.</p> | | |
| <p>Criterion 2.4.4</p> <p>Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided.</p> | PA Low | <p>Staff interviewed advised new staff are provided with an orientation, and a checklist is used to tick off required topics. New staff are buddied with senior staff and are shown the facility, emergency/fire procedures, individual residents and their needs, use of equipment, and</p> | <p>Three out of five staff records reviewed did not have evidence staff had completed orientation requirements.</p> | <p>Ensure all new staff complete a role-specific orientation and records are retained.</p> <p>180 days</p> |

| | | | | |
|--|------------------------|---|---|---|
| | | <p>policies and processes.</p> <p>Orientation records were missing from three out of five staff files reviewed. These comprised one staff member employed in 2019 and two staff members employed in 2023. One staff member has just commenced and was working through the orientation programme.</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> | <p>PA Moderate</p> | <p>InterRAI assessments are completed by the nurse manager in consultation with the residents and family members. The interRAI database could not be accessed to verify that all interRAI assessments were completed in a timely manner. Therefore, the previous area requiring improvement remains open. Two of the five resident files reviewed had no completed interRAI assessments in place in the records available for review.</p> | <p>(i)Records were not available to demonstrate that all residents had current interRAI assessments in place.</p> <p>(ii)Two of the five residents' files reviewed had no completed interRAI assessments in place.</p> | <p>Ensure records of completed interRAI assessments are available on request and residents who require an interRAI assessment have one completed in a timely manner.</p> <p>90 days</p> |
| <p>Criterion 3.2.5</p> <p>Planned review of a person's care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau,</p> | <p>PA Moderate</p> | <p>The owner/manager reported that interRAI assessments are completed by the nurse manager (NM) who has a current interRAI competency. Five residents' files reviewed evidenced that outcome scores from interRAI assessments were not identified on the long-term care plans and relevant</p> | <p>(i) Some of the outcome scores from interRAI assessments were not identified on long-term care plans and there were no appropriate interventions to address this.</p> <p>(ii) There were no Pacific health plans developed for residents who identify as Pasifika.</p> | <p>(i) Ensure all outcome scores from assessments are identified with relevant interventions developed.</p> <p>(ii) Ensure residents who identify as Pasifika have a Pacific health plan in place.</p> <p>(iii) Complete residents'</p> |

| | | | | |
|--|-------------------------|---|---|--|
| <p>together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (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; (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>interventions developed. Pasifika residents' files reviewed had no Pacific health plan in place addressing their cultural needs. There were two residents who were not competent in decision making, using bed rails as a restraint; however, there were no assessments, consent, or monitoring forms being completed as per policy requirements.</p> <p>Bedridden residents had turning charts initiated; however, these were not consistently completed.</p> <p>Incident forms were completed for all residents' fall incidents, but neurological monitoring of residents post unwitnessed falls was not occurring as required by policy for any of the four applicable events sampled, although monitoring for one resident post fall was more comprehensive.</p> <p>Residents have a nutrition profile developed on admission which identifies dietary requirements, likes, and dislikes. Resident nutritional profiles were not reviewed six-monthly as required.</p> | <p>(ii) Resident nutritional profiles were not reviewed six-monthly as required.</p> <p>(iv) Neurological monitoring of residents post unwitnessed falls was not occurring as per policy requirements.</p> <p>(v) Turning charts were not consistently completed as per policy requirements.</p> <p>(vi) Restraint assessments, consent, and monitoring were not completed for residents using bedrails and safety belts.</p> | <p>nutritional profiles six-monthly as required.</p> <p>(iv) Ensure neurological observations are completed post unwitnessed falls or when there is a suspected head injury.</p> <p>(v) Consistently complete turning charts as per policy requirements.</p> <p>(vi) Ensure an assessment, consent and monitoring process is completed for residents using a restraint.</p> <p>90 days</p> |
| <p>Criterion 3.3.1 Meaningful activities shall be planned and facilitated to develop and enhance</p> | <p>PA Moderate</p> | <p>Click here to enter text</p> | <p>No evidence of an individualised activities programme.</p> | <p>Provide evidence of an individualised activities programme.</p> |

| | | | | |
|--|--------|---|--|--|
| people's strengths, skills, resources, and interests, and shall be responsive to their identity. | | | | 90 days |
| <p>Criterion 3.4.1</p> <p>A medication management system shall be implemented appropriate to the scope of the service.</p> | PA Low | <p>Monitoring of medicine fridge temperatures was completed, and this was evidenced in records sighted. An improvement is required to ensure the ambient temperature of the medication room are monitored and within an accepted temperature range. PRN medications were stored in the drug trolley and medication room. During an inspection of the medication storage areas, there were expired PRN medications currently in use.</p> | <p>(i) Medication room temperature monitoring was not completed as required.</p> <p>(ii) Expired PRN medications were currently in use and kept in the drug trolley and medication room.</p> | <p>(i) Ensure medication room temperatures are completed as per policy and current accepted standards of practice.</p> <p>(ii) Ensure expired PRN medications are not used and returned to the pharmacy in a timely manner.</p> <p>90 days</p> |
| <p>Criterion 5.2.2</p> <p>Service providers shall have a clearly defined and documented IP programme that shall be:</p> <p>(a) Developed by those with IP expertise;</p> <p>(b) Approved by the governance body;</p> <p>(c) Linked to the quality improvement programme; and</p> <p>(d) Reviewed and reported on annually.</p> | PA Low | <p>The service has a clearly defined and documented IP programme implemented that was developed with input from external IP services. The IP programme was approved by the owner/manager and is linked to the quality improvement programme. However, the IP programme was not reviewed annually as per standard requirements. The IP policies were developed by suitably qualified personnel and comply with relevant legislation and accepted best practices. The IP policies reflect the requirements of the infection</p> | <p>There was no evidence of an annual review of the IP programme.</p> | <p>Ensure that the IP programme is reviewed annually to meet the standard requirement.</p> <p>180 days</p> |

| | | | | |
|--|--------|---|--|--|
| | | prevention and control standards and include appropriate referencing. The staff understood the implemented infection prevention and control policies and procedures. | | |
| <p>Criterion 6.1.1</p> <p>Governance bodies shall demonstrate commitment toward eliminating restraint.</p> | PA Low | <p>Organisation policy has a commitment to eliminating the use of restraint. However, at governance and operational level restraints are being used. The restraints used are bed rails and lap belts and are being used for patient safety, to stop the resident falling out of a bed or chair. The owner interviewed stated an understanding that if bed rails and lap belts were being used for safety purposes they were not considered as restraint. This included residents unable to give consent or to ask for restraints to be removed. There were two residents not competent in decision-making using bed rails as a restraint in sampled resident files. However, there were no assessments, consent, or monitoring forms being completed as per policy requirements. This is included in the area for improvement raised in criterion 3.2.5.</p> <p>The owner noted after reviewing the definitions in the standards that four residents would be now</p> | <p>Organisation policy has a commitment to eliminating the use of restraint. However, at governance and operational level restraints are being used and there is a misunderstanding of what restraint is. Restraint use is being incorrectly reported in most staff meeting minutes as having been eliminated/no use of restraint.</p> | <p>Ensure managers/governance understanding of restraint aligns with Ngā Paerewa.</p> <p>Ensure accurate information on the restraint elimination strategy is accurately reported on in staff meeting minutes.</p> <p>180 days</p> |

| | | | | |
|---|---------------------------|--|---|--|
| | | <p>considered to have restraints in use.</p> <p>A family member of a resident with restraints in use was interviewed. The family member confirmed they were happy with bedrails used for safety reasons.</p> | | |
| <p>Criterion 6.1.6</p> <p>Health care and support workers shall be trained in least restrictive practice, safe practice, the use of restraint, alternative cultural-specific interventions, and de-escalation techniques within a culture of continuous learning.</p> | <p>PA</p> <p>Moderate</p> | <p>Staff interviewed could detail that restraint restricted residents' freedom of movement and noted that there were residents with restraints in use. Restraints were observed at audit. Staff noted these were for safety and prevent residents falling out of bed or the chair.</p> <p>Training on restraint elimination, alternatives and de-escalation techniques has not occurred since 2019 in the staff training records provided.</p> | <p>Training on restraint elimination, alternatives and de-escalation techniques has not occurred since 2019 in the staff training records provided.</p> | <p>Ensure staff are provided with training on restraint elimination, alternatives and de-escalation techniques as part of the ongoing education and competency framework.</p> <p>90 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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 audit.

| |
|--------------------|
| No data to display |
|--------------------|

End of the report.