# Anne Maree Court Care Limited - Anne Maree Court Rest Home

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

The audit has been conducted by BSI Group New Zealand Ltd, 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Anne Maree Court Care Limited

**Premises audited:** Anne Maree Court Rest Home

**Services audited:** Hospital services - Medical services; Rest home care (excluding dementia care); Residential disability services - Physical

**Dates of audit:** Start date: 19 August 2024 End date: 20 August 2024

**Proposed changes to current services (if any):** The service requests the residential disabilities (physical) is reinstated to the certificate Hospital (geriatric) services also needs to be added to the certificate.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 57

# 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 haumaru │ 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 |
|  | 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

Anne Maree Court is a privately owned facility certified to provide rest home level of care, hospital level care, and residential disability services – physical for up to 57 residents. There were 57 residents on the day of audit.

The certification audit was conducted against the Ngā Paerewa Health and Disability Service Standard 2021 and the contracts with Health New Zealand Te Whatu Ora - Waitematā. The audit process included observations, a review of policies and procedures, review of residents’ and staff files, and interviews with residents, family members, managers, staff, and a general practitioner.

The manager (non-clinical) is appropriately qualified and experienced. She is supported by a clinical manager and a team of experienced care staff. There are quality systems and processes not comprehensively implemented.

An induction and in-service training programme are to be fully implemented to provide staff with appropriate knowledge and skills to deliver care.

The certification audit identified shortfalls related to communication; complaints management; implementation of the quality and risk management systems; staff roster and staff training; staff files; interRAI timeframes; care plan interventions, monitoring and evaluations; medication management; infection prevention and control; restraint management and processes.

## Ō tātou motika │ Our rights

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| --- | --- | --- |
| 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. |

The business plan includes a mission statement, values, and operational objectives. Staff demonstrated an understanding of residents' rights and obligations. There is a Māori health plan and a Pacific health plan. The service aims to provide high-quality and effective services and care for residents.

Residents receive services in a manner that considers their dignity, privacy, and independence. Ann Maree Court provides services and support to people in a way that is inclusive and respects their identity and their experiences. The service listens and respects the voices of the residents and effectively communicates with them about their choices. Care plans accommodate the choices of residents and/or their family/whānau.

The rights of the resident and/or their family/whānau to make a complaint is understood, respected, and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed.

## Hunga mahi me te hanganga │ Workforce and structure

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| --- | --- | --- |
| Includes five 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. |

The service has documented quality and risk management systems that takes a risk-based approach. A health and safety system is in place. Health and safety processes are embedded in practice. Health and safety policies are implemented and monitored by the health and safety committee. Staff incidents, hazards and risk information is collated at facility level.

The human resources policies include recruitment, selection, orientation, and staff training and development. The service has an established orientation programme that provides new staff with relevant information for safe work practice. The annual education schedule documented included all required topics around caring for residents with disabilities and those at hospital and rest home level of care. The roster provides sufficient and appropriate coverage for the effective delivery of care and support.

The service ensures the collection, storage, and use of personal and health information of residents and staff is secure, accessible, and confidential.

## Ngā huarahi ki te oranga │ Pathways to wellbeing

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| --- | --- | --- |
| 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. |  | Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Anne Maree Court’s policies and procedures provide documented guidelines for access to the service. Residents are assessed before entry to the service to confirm their level of care. The registered nurses (RNs) are responsible for the assessment, development, and evaluation of care plans. There is a process to ensure care plans are individualised and based on the residents’ assessed needs and routines.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activity plans are completed in consultation with family/whānau and residents noting their activities of interest. In interviews, residents and family/whānau expressed satisfaction with the activities programme in place.

There is a medicine management system in place. All medications are reviewed by the general practitioner (GP) every three months. Staff involved in medication administration are assessed as competent to do so. Evidence of completed current medication competencies was sighted.

The food service provides for specific dietary likes and dislikes of the residents. Nutritional requirements are met. The service has a current food control plan in place. Resident’s requests are accommodated.

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

## Te aro ki te tangata me te taiao haumaru │ Person-centred and safe environment

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| --- | --- | --- |
| 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. |  | Subsections applicable to this service fully attained. |

The facility meets the needs of residents, was clean and maintained. There was a current building warrant of fitness in place. Electrical and equipment requiring calibration has been tested as required. External areas are accessible, safe and provide shade and seating and meet the needs of people with disabilities. Resident rooms are personalised, and communal facilities are appropriate. Staff are trained in emergency procedures, use of emergency equipment and supplies, and attend regular fire drills. Staff, family/whānau, and contractors understood emergency and security arrangements. Sensor mats are in place connected to the nurse call system. Security is maintained.

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

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

The infection prevention and control programme, content and detail is appropriate for the size, complexity, and degree of risk associated with Anne Maree Court. A suite of infection prevention and control policies and procedures guide staff. The infection prevention and control coordinator is a registered nurse.

The infection prevention and control programme is designed to link to the quality and risk management system. The programme has been reviewed annually. Infection prevention and control is an agenda item in the monthly quality and risk meeting. The pandemic plan is in place and there is sufficient personal protective equipment (PPE) available.

Chemicals are stored securely throughout the facility. Staff have not received training on safe and appropriate handling of waste and hazardous substances at orientation.

Dedicated household staff provide safe management of dirty and clean laundry. Documented cleaning and laundry services policies and procedures are in place.

## Here taratahi │ Restraint and seclusion

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| 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 partially attained and of low risk. |

The restraint coordinator is the registered nurse. There are currently five restraints in use in the form of lap belts, and bed rails. Restraint assessment, interventions, monitoring, and evaluation have been completed. The service considers least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort. Anne Maree Court is working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.

## Summary of attainment

The following table summarises the number of subsections and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 18 | 0 | 8 | 3 | 0 | 0 |
| **Criteria** | 0 | 162 | 0 | 11 | 7 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Subsection with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Subsection 1.1: Pae ora healthy futures  Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. 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. | FA | The Māori health plan and associated cultural policies acknowledges Te Tiriti o Waitangi as a founding document for New Zealand. The service has residents who identify as Māori. Anne Maree Court is committed to respecting the self-determination, cultural values, and beliefs of Māori residents and family/whānau. The aim of this plan is equitable health outcomes for Māori residents and their whānau with overall improved health and wellbeing. Areas of focus have been identified in the Māori health plan using Te Whare Tapa Whā as the tool to assist in their delivery of services for Māori, which reflects the four cornerstones of Māori health.  The resident care plans include a Māori health care plan based on Te Whare Tapa Whā. Records for residents identifying as Māori were reviewed and these confirmed that a Māori health care plan had been completed. The service has well established links with the Health New Zealand – Waitemata cultural advisor. Recently, residents visited the Matariki Art Gallery exhibition to celebrate Matariki. Further to this the residents celebrate Māori language week and staff and residents are learning te reo and singing songs in te reo.  The facility manager interviews all suitably qualified Māori applicants when they apply for employment opportunities at Anne Maree Court. At the time of the audit there were staff members who identified as Māori and who are working to improve their te reo Māori. The business plan documents a commitment and responsiveness to a culturally diverse workforce. All staff have access to relevant tikanga guidelines. Te reo Māori is encouraged to be used in general conversations. Staff have completed modules in an electronic training programme relating to cultural safety.  Residents and family/whānau are involved in providing input into the resident’s care planning, activities, and dietary needs. Thirteen staff were interviewed (six healthcare assistants (HCA), two registered nurses (RNs), two cooks, one kitchen hand, one diversional therapist and one household staff) and three managers (the director, the facility manager and clinical manager) confirmed all cultures were treated equally and welcomed to the workplace. Healthcare assistants and registered nurses were able to describe how care is based on the resident’s individual values, preferences, and beliefs. |
| Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa  The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes. | FA | A Pacific health plan is documented that focuses on achieving equity and efficient provision of care for Pasifika. The service aims to achieve optimal outcomes for Pasifika. Pacific culture, language, faith, and family values form the basis of their culture and are therefore important aspects of recognising the individual within the broader context of Pasifika. The Pacific health plan has been developed by an external consultant. The policy is based on the Ministry of Health Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025.  On admission all residents state their ethnicity. Family members of Pacific residents are encouraged to be present during the admission process, including completion of the initial care plan. Individual cultural beliefs are documented in each resident care plan and activities plan. There were residents who identified as Pasifika at the time of audit who confirmed their cultural needs were being met.  Anne Maree Court partners with their Pasifika employees to ensure connectivity within the region to increase knowledge, awareness and understanding of the needs of Pacific people and celebrating cultural ceremonies. They have fostered close relationships with elders in the community churches. The Health and Disability Commissioner’s (HDC) Code of Health and Disability Code of Rights (the Code) are accessible in a range of Pasifika languages. |
| Subsection 1.3: My rights during service delivery  The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements. | FA | The Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) is displayed in English and te reo Māori. Details relating to the Code are included in the information that is provided to new residents and their family/whānau. The clinical manager or registered nurses discuss aspects of the Code with residents and their family/whānau on admission.  Discussions relating to the Code are held during the resident meetings. The eleven residents interviewed (eight rest home including four younger residents with a disability (YPD) and three hospital including one YPD) and four family/whānau (one rest home and three hospital including one for a YPD resident) reported that the residents’ rights are being upheld by the service. Interactions observed between staff and residents during the audit were respectful. There are links to spiritual supports.  Information about the Nationwide Health and Disability Advocacy Service is available to residents at the entrance and in the entry pack of information that is provided. Staff have not received education in relation to the Code as scheduled (link 2.3.4). Advocacy services are linked to the complaints process. The service recognises Māori mana motuhake: self-determination, independence, sovereignty, authority, as evidenced through interviews, policy and procedures, the range of activities provided, and the service’s commitment to providing a service that meets the needs of whaikaha, people with disabilities. |
| Subsection 1.4: I am treated with respect  The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences. | FA | Interviews with staff described how they support residents in making their own choices. Residents interviewed confirmed this to be the case, and that they have control and choice over activities they participate in. Residents are supported to make decisions about whether they would like family/whānau members to be involved in their care.  Residents were observed to be treated with dignity and respect. This was also confirmed during interviews with residents and family/whānau.  A sexuality and intimacy policy is in place. Staff interviewed stated they respect each resident’s right to have space for intimate relationships. Staff were observed to use person-centred and respectful language with residents. Residents interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy is ensured and independence is encouraged.  Eight residents' files reviewed identified residents’ preferred names. Values and beliefs information is gathered on admission with family/whānau involvement and is integrated into the residents' care plans. Spiritual needs are identified. A spirituality policy is in place.  Te reo Māori signage was evident around the facility. Te Tiriti o Waitangi and tikanga Māori training have not been completed (link 2.3.4). The Māori health plan acknowledges te ao Māori, referencing the interconnectedness and interrelationship of all living and non-living things. Written information referencing Te Tiriti o Waitangi is available for residents and staff to refer to.  Younger residents and family/whānau interviewed by the consumer auditor stated that they make their own decisions and are treated with respect. The majority felt supported by staff to ensure their beliefs and identity are maintained. |
| Subsection 1.5: I am protected from abuse  The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse. | FA | An abuse and neglect policy is being implemented. Anne Maree Court policies aim to prevent any form of discrimination, coercion, harassment, or any other exploitation. Cultural days are held to acknowledge cultural diversity. There are education modules on how to value the older person, showing them respect and dignity. Residents and family/whānau interviewed confirmed that the staff are caring, supportive, and respectful.  The service implements a process to manage residents’ comfort funds, such as sundry expenses. Further to this, the service supports younger residents to be independent in managing their finances by providing a safe and secure environment to do this, along with mentorship from external agencies, such as budget advisors. Professional boundaries are defined in job descriptions. Interviews with the management, registered nurses and healthcare assistants confirmed their understanding of professional boundaries, including the boundaries of their job role and responsibilities. Professional boundaries are covered as part of orientation. Interviews with staff confirm that they would be comfortable addressing racism with management, if they felt that this was an issue.  A strengths-based and holistic model is prioritised in the Māori health plan to facilitate wellbeing outcomes for Māori residents. |
| Subsection 1.6: Effective communication occurs  The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices. | PA Low | A range of information is provided to residents and family/whānau on admission in the Anne Maree Court welcome pack. Three monthly resident meetings identify feedback from residents and consequent follow up by the service (link 2.2.2).  Policies and procedures relating to accident/incidents, complaints, and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. All communication with family/whānau is documented in the resident’s file; however, there is no evidence that family/whānau were always informed following adverse events. Family/whānau interviewed stated that they are kept informed when their family/whānau member’s health status changes or when they have been seen by the general practitioner.  An interpreter policy and contact details of interpreters are available. Interpreter services are used where indicated. At the time of the audit, there were residents who did not speak English. Family/whanau interpreters, staff who speak the language, google translate and cue cards were used to ensure effective communication.  Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family/whānau are informed prior to entry of the scope of services and any items that are not covered by the agreement.  The delivery of care includes a multidisciplinary team approach. Health professionals involved with the residents may include specialist services through Health New Zealand- Waitemata and other agencies as required. The clinical manager and registered nurses described an implemented process around providing residents with time for discussion around care, time to consider decisions, and opportunities for further discussion, if required. |
| Subsection 1.7: I am informed and able to make choices  The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. 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. | FA | There are policies documented around informed consent. The eight resident files reviewed included signed general consent forms and other consents, including vaccinations, outings, and photographs. Residents and family/whānau interviewed could describe what informed consent was and knew they had the right to choose.  The advance directive policy is implemented. In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. Discussions with family/whānau demonstrated they are involved in the decision-making process, and in the planning of resident’s care. Admission agreements are signed and were sighted in all the files seen. Copies of enduring power of attorneys (EPOAs) and activation letters were on resident files where required. Māori tikanga guidelines were available for staff to ensure they can provide appropriate information for residents, family/whānau and in care planning as required. |
| 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. | PA Low | The complaints procedure is provided to residents and family/whānau on entry to the service and is available in te reo Māori. The facility manager is responsible for maintaining the complaints register and evidenced the complaint documentation process. The process includes acknowledgement, investigation, follow-up letters and resolution to demonstrate that complaints are managed in accordance with guidelines set by the Health and Disability Commissioner. There have been two documented complaints since the previous audit.  The facility manager reported that the complaint process timeframes are adhered to. In the event of a complaint, documentation including follow-up letters and resolution, would be completed, and managed in accordance with guidelines set by the Health and Disability Commissioner. Discussions with residents and family/whanau confirmed they are provided with information on the complaints process and noted concerns or issues they had, are generally addressed; however, there were verbal complaints which were not sighted in the complaints register on the day of the audit.  Complaints forms and advocacy brochures are available at the entrance to the facility. Residents have a variety of avenues they can choose from to lodge a complaint or express a concern (e.g., verbally, in writing, through an advocate). Resident meetings are held three-monthly also provide a platform to raise any concerns residents have. The facility manager, clinical manager and staff encourage residents and family/whānau to discuss any concerns. It is an equitable process for all cultures.  Residents and family/whānau making a complaint are supported to involve an independent support person in the complaints process if they choose. The facility manager, clinical manager and registered nurses acknowledged the importance of face-to-face communication with Māori and the service maintains an open-door policy. |
| Subsection 2.1: Governance  The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. 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. 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. | PA Low | Anne Maree Court, located in Northcote, Auckland, provides rest home level of care, hospital level care, and residential disability services – physical, for up to 57 residents. All 57 beds are certified as dual purpose. On the day of the audit, there were 57 residents; 28 at rest home level of care, including five on the younger person with a disability (YPD) contract and three on the long-term support- chronic health care (LTS-CHC) contract; 29 hospital level residents, including one on Accident Compensation Corporation (ACC) funding, four on YPD contract and two LTS-CHC. The remaining residents being under the age-related residential care contract (ARRC). The service requests the residential disabilities (physical) is reinstated to the certificate.  The owner/director (executive governance) is the governing body for Anne Maree Court trading as Anne Maree Court Care Limited. Interview with the director confirmed that there are two shareholders (including the director). Anne Maree Court is one of five facilities in the north island owned and operated by the director. There is a senior management team based at the head office who are available to provide support as required. The director was knowledgeable in the requirements to meet the Health and Disability Standards and obligations under the contract. The director and facility manager have monthly meetings, and the director visits the facility at least twice a month and is available via email or over the phone as and when required. However, review of the monthly facility manager’s report to governance does not evidence incorporation of quality and risk issues.  The director and facility manager were able to describe the company quality goals, organisation philosophy and strategic plan which reflect a resident and family/whanau centred approach to all services. There is a 2023-2025 business plan that outlines key objectives for the period. These include (but not limited to); continue to provide good quality long term care service; maintain at least 95% occupancy; establish and maintain long term relationships with cultural advisory groups for Māori and Pasifika residents; continue to maintain good relationships for palliative care; maintain good staff retention; provide variety of training.  The service is managed by the facility manager who has been in the role since November 2023. They hold a postgraduate diploma (NZQA Level 8) in Health Science (Healthcare Management & Digital Health Transformation) as well as a diploma (NZQA Level 7) in Healthcare Services Management. They are supported by a clinical manager who was appointed to the role in October 2023, having worked at the facility since 2021 as a registered nurse. The clinical manager has oversight of clinical governance.  The governance and leadership structure, including clinical governance, is appropriate to the size and complexity of the service. Both managers have maintained at least eight hours of professional development activities related to managing a rest home including aspects covered as part of orientation which has included cultural safety training. The director is planning to undertake formal training around Te Tiriti and cultural safety. The director is learning through the Māori staff to inform practice in relation to Te Tiriti.  The facility manager consults with mana whenua (via staff members) in business planning, organisational policy, and service development to improve outcomes and achieve equity for Māori, and to identify and address barriers for Māori for equitable service delivery. This consultation also assists the organisation to explore and implement solutions on ways to achieve equity and improve outcomes for tāngata whaikaha.  Residents receiving services and family/whānau are supported to participate in the planning, implementation, monitoring, and evaluation of service delivery through surveys, meetings, and an open-door management policy. |
| Subsection 2.2: Quality and risk  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. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. 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. | PA Moderate | There is a quality and risk management programme for Anne Maree Court. The quality and risk management programme includes performance monitoring through internal audits and through the collection of clinical indicator data (e.g., falls, medication errors, infections, skin integrity/tears, complaints, restraints).  The staff meetings provide an avenue for discussions in relation to (but not limited to): quality data; health and safety; infection control/pandemic strategies; complaints received (if any); cultural compliance; internal audit compliance; staffing; and education. However, the staff meetings have not been completed as scheduled and there was no evidence of key risk areas being discussed. Internal audits, meetings, and collation of data were not taking place as scheduled. Where corrective actions were identified there was no evidence of follow-up and sign off when completed.  Quality and infection data collation occurred each month and was documented in the staff meeting minutes and available for staff to see. However, there was no evidence of quality data and trends in data being analysed and implementation of quality improvements as indicated. Corrective actions are not always discussed in meetings to ensure any outstanding matters are addressed and signed off when completed. Quality data analysis including benchmarking, feedback through residents’ meetings and complaints management have not been completed to provide an avenue for critical analysis of work practices.  Cultural safety is embedded in the quality system. Cultural awareness training has occurred and staff who identify as Māori ensure high quality services are provided for Māori. Tāngata whaikaha have meaningful representation through three monthly resident meetings (these have not always occurred as scheduled) and six-monthly care plan reviews.  The results of the June 2024 resident and family/whānau satisfaction survey results have not been collated and analysed to inform any quality improvements. The residents, family/whānau and staff have not received the results. Interviews with residents and family/ whānau on the days of the audit demonstrated satisfaction with the service provision. This included feedback from YPD residents and family/whanau of those under YPD contract.  A document control system is in place. Policies are developed and reviewed by the external contractor and the management team and meet the Ngā Paerewa Health and Disability Services Standard 2021. New policies or changes to policy are communicated and discussed with staff.  A health and safety system is being implemented. Manual handling training sessions and hoist competencies are in place for staff. The facility manager (health and safety representative) has completed external health and safety training. Hazard identification forms and an up-to-date hazard register are in place; issued in November 2023. Hazards are classified by their risk and priority. Staff incidents, hazards and other health and safety issues are discussed monthly as part of the staff meetings.  Electronic reports are completed for each incident/accident. Infection, incident and accident data is collated monthly; however, there is no evidence of it being analysed. Infection, incident and accident data results are included in staff meeting minutes and discussed at handover. Opportunities to minimise future risks are identified by the clinical manager in consultation with registered nurses and healthcare assistants. The internal audit on accident and incident reporting has not been completed.  Discussions with the facility manager and clinical manager reflected their awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been one WorkSafe notification completed in June 2024 and one section 31 notification related to resident behaviour that involved the police; however, not all notifications have been completed. There have not been any outbreaks since last audit. |
| Subsection 2.3: Service management  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. | PA Low | There is a staffing policy, with a staff and contingency shortfall plan which describes rostering requirements. The roster provides sufficient and appropriate cover for the effective delivery of care and support. Anne Maree court have a full complement of registered nurses to provide a 24/7 cover. There have not been any section 31 notifications related to registered nurse cover completed since last audit. The rosters reviewed evidence any vacancies and unplanned absence have not always been covered. Review of the registered nurse roster confirms that there is always one registered nurse each shift with the clinical manager covering two morning shifts as the registered nurse on duty. The registered nurses are supported by medication competent level four healthcare assistants.  Healthcare assistants reported on interview that staffing is adequate. The roster reviewed for the last two weeks was not fully covered or backfilled when staff were absent on short notice. Residents and family/whānau interviewed confirmed their care requirements are attended to in a timely manner. The facility manager interviewed confirm that they are in the process of recruiting more healthcare assistants.  The facility manager, clinical manager, registered nurses, healthcare assistants, and diversional therapist hold current first aid certificates to ensure there is at least one member of staff on duty and on outings at all times with current first aid training. The facility manager and the clinical nurse manager work full-time (Monday to Friday). The registered nurses on shift manage most of the queries and staffing cover. The clinical manager and facility manager provide on call support out of hours.  The Māori health plan includes objectives around establishing an environment that supports culturally safe care through learning and support. There is an annual education and training schedule in place. The education and training schedule lists compulsory training which includes cultural awareness training. External training opportunities for care staff include training through Health New Zealand, Waitakere Hospital and hospice. However, review of records does not evidence that staff have completed training as scheduled with the exception of cultural awareness, privacy and emergency evacuation.  Staff are encouraged to participate in learning opportunities that provide them with up-to-date information on Māori health outcomes and disparities, and health equity. Staff confirmed that they are provided with resources during their cultural training and sharing information. Māori staff also share information and whakapapa experiences to support learning about and address inequities.  The service supports and encourages healthcare assistants to obtain a New Zealand Qualification Authority (NZQA) qualification. Twenty HCAs are employed; 11 hold the NZQA national certificate in health and wellbeing level four; three are at level three; one at level two and the remaining five at level zero.  All staff are required to complete competency assessments as part of their orientation. Additional registered nurse specific competencies include subcutaneous fluids, syringe driver and interRAI assessment competency. Four registered nurses are interRAI trained.  All HCAs are required to complete competencies at orientation. Annual competencies include for restraint, moving and handling, hand hygiene and cultural competencies. A selection of HCAs completes annual medication administration competencies. A record of completion is maintained and is current.  There are documented policies to manage stress and work fatigue. Staff could explain workplace initiatives that support staff wellbeing and a positive workplace culture. Staff are provided with opportunity to participate and give feedback at staff meetings, employee surveys and performance appraisals. Staff wellness is encouraged through participation in health and wellbeing activities and initiatives. Signage supporting counselling programmes are posted in visible staff locations. Interviews with staff confirmed that they feel supported by their managers and workplace initiatives are encouraged. |
| Subsection 2.4: Health care and support workers  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. 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. 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. | PA Low | Human resource policies are in place, including recruitment, selection, orientation, and staff training and development. Six staff files were reviewed and evidenced implementation of the recruitment process, employment contracts and police vetting; however, not all files evidenced completed orientation programmes. All staff have been employed by the new provider for less than a year therefore there were no appraisals due. Job descriptions are in place for all positions and cover outcomes, accountability, responsibilities, authority, and functions to be achieved in each position; however, these were not always available in the files reviewed. A register of practising certificates is maintained for all health professionals.  The service has a role specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation and updated at prescribed timeframes. The service demonstrates that the orientation programme supports staff to provide a culturally safe environment to Māori and other ethnic groups.  Information held about staff is kept secure and confidential. Ethnicity data is identified and collated during the employment process. The service has policies related to a debriefing process following incidents. There are staff wellbeing support programmes in place. |
| Subsection 2.5: Information  The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential. | FA | All resident and staff files are kept secure. Resident files and the information associated with residents and staff are retained and archived. Electronic information is regularly backed-up using cloud-based technology and password protected.  The resident files are appropriate to the service type and demonstrated service integration. Records are uniquely identifiable, legible, and timely. Signatures that are documented include the name and designation of the service provider. Hardcopy documents are securely stored in a locked room and easily retrievable when required.  Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. The facility manager is the privacy officer and there is a pathway of communication and approval to release health information. The service is not responsible for National Health Index registration. |
| Subsection 3.1: Entry and declining entry  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. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau. | FA | The admission policy for the management of inquiries and entry to Anne Maree Court is in place. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the enduring power of attorney (EPOA)/whānau/family of choice, where appropriate, local communities, and referral agencies. Completed Needs Assessment and Service Coordination (NASC) service authorisation forms for residents assessed as requiring rest home, hospital, YPD, and respite level of care was in place.  Records reviewed confirmed that admission requirements are conducted within the required timeframes and are signed on entry. The facility manager (FM) and clinical manager (CM) reported that the rights and identity of the residents will be protected by ensuring residents’ information is kept confidential in locked cupboards, and secure electronic systems. EPOA/whānau/family were updated where there was a delay to entry to service; this was observed in inquiry records sampled. Residents and family/whānau interviewed confirmed that they were consulted and received ongoing sufficient information regarding the services provided.  The FM and CM reported that all potential residents who are declined entry are recorded. When an entry is declined, relatives are informed of the reason for this and made aware of other options or alternative services available. The resident and/or family/whānau is referred to the referral agency to ensure the person will be admitted to the appropriate service provider. There were residents of Māori descent and there were Māori staff members.  The service completes routine analysis to show entry and decline rates, including specific data for entry and decline rates for Māori is implemented.  The service partners with local Māori communities, Māori health practitioners, traditional Māori healers and organisations to benefit and support Māori individuals and whānau. |
| Subsection 3.2: My pathway to wellbeing  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. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing. | PA Moderate | Eight electronic resident files were reviewed: four rest home, including one on a LTS-CHC; and four hospital level, including one ACC respite and one younger person with a disability (YPD).  All files sampled identified that initial assessments and initial care plans were resident centred, and these were completed within the required timeframes. 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 RNs and HCA staff.  InterRAI assessments were completed for residents (inclusive of YPD and LTS-CHC) and long term care plans were in place for all residents; however, not all interRAI assessments and long term care plans were developed within the required timeframes. Not all interRAI reassessments have been completed within the six month timeframe. Long term care plans had detailed interventions to address identified problems; Resident, family/whānau and GP involvement are encouraged. Long-term care plans were reviewed at least six-monthly. The care plan evaluations included the residents’ degree of progress towards their agreed goals and aspirations as well as whānau goals and aspirations. Detailed strategies to maintain and promote the residents’ independent wellbeing, and where appropriate early warning signs and risks that may affect a resident’s wellbeing, were documented in most cases.  The respite resident had appropriate risk assessments completed, and a care plan documented.  The GP visits the service once per week and is available on call 24/7. Residents’ medical admission and reviews were completed within the required timeframes. Completed medical records were sighted in all files sampled. Residents’ files sampled identified service integration with other members of the health team. Multidisciplinary team (MDT) meetings were completed annually. The GP confirmed that medical input was sought within an appropriate timeframe, medical orders were followed, and care was person-centred. This was evidenced in the files reviewed.  Information is shared between the staff at each handover, as observed on the days of audit. Interviewed staff stated that they are 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. A multidisciplinary approach is adopted to promote continuity in service delivery.  Short-term care plans were developed for short-term problems or in the event of any significant change with appropriate interventions 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 is reported to the CM or FM and RNs and this was evidenced in the records sampled. Interviews verified residents and family/whānau are included and informed of all changes.  There were ten active wounds, including two pressure injuries (stage 2, and stage 3) at the time of the audit. There is a wound folder of all active wounds. All wounds have individual assessments, wound management plans and evaluations forms, with photos to evidence progression towards healing. The same information is also entered on the electronic resident management system. The CM and RN reported that the Health New Zealand - Waitematā wound nurse specialists and GP have input into chronic wound management when required. A range of equipment and resources were available, suited to the levels of care provided and the residents’ needs. The EPOA/whānau/family and residents interviewed confirmed their involvement in the evaluation of progress and any resulting changes.  The Māori health care plan in place reflects the partnership and support of residents, whānau, and the extended whānau as applicable to support wellbeing. Tikanga principles are included within the Māori health care plan. Any barriers that prevent tāngata whaikaha and whānau from independently accessing information would be identified and strategies to manage these documented. Residents with a disability (including younger people) are involved in planning their care and provide feedback to the service through surveys and resident meetings. Enduring power of attorney (EPOA)/whānau/family confirmed that religious, cultural and beliefs are respected. The staff confirmed they understood the process to support residents and whānau.  The following monitoring charts were completed in assessing and monitoring residents: fluid balance charts; turn charts; nursing observations; wound monitoring forms; blood glucose; and restraint monitoring charts; however, neurological observations were not completed as per policy. Incident reports reviewed evidenced timely follow up by an RN. |
| Subsection 3.3: Individualised activities  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. | FA | Planned activities are appropriate to the residents’ needs and abilities. Activities are conducted by the activity’s coordinator Monday to Friday and facilitated by other staff members during the weekend. The activities are based on assessment and reflected the residents’ social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents’ birthdays are celebrated. A resident profile is completed for each resident within two weeks of admission in consultation with the EPOA/whānau/family and residents.  The activity programme is formulated by the activity’s coordinator in consultation with the CM, RNs, EPOAs, residents, and HCAs. The activities are varied and appropriate for people in a rest home and hospital setting. YPD residents engage with other residents in the activities programme at the service; where preferred, one on one and group activities are arranged. Residents’ activity care plans were evaluated every six months or when there was any significant change. Van trips are conducted twice weekly, and there is a community walking group that goes once a week (weather permitting).  Activity progress notes and activity attendance checklists were completed daily on the electronic record management system. The residents were observed participating in a variety of activities on the audit days. The activity planner sighted included: music; bingo; happy hour; book reading; indoor golf; floor and board games; trivial pursuit and general knowledge; knitting group; bus outing/sightseeing; church services; and therapeutic massage. A number of activities were observed during the time of audit, and were seen to be lively, inclusive, and had high levels of resident participation.  The planned activities and community connections are suitable for the residents. The activities coordinator reported that opportunities for Māori and whānau to participate in te ao Māori are facilitated through community engagements facilitated by current staff members and whanau. Māori and Pacific residents are encouraged to celebrate religious and cultural festivals, with Māori residents attending the local marae and cultural events are celebrated.  Relatives and residents reported high levels of satisfaction with the level and variety of activities provided. |
| Subsection 3.4: My medication  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. | PA Moderate | There is a medication management policy in place. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Administration records are maintained, and drug incident forms are completed in the event of any drug errors.  Indications for use are noted for pro re nata (PRN) medications. Outcomes of PRN medications were documented for effectiveness. Over-the-counter medications, and supplements are prescribed. Allergies are indicated, and photos were current. Eye drops in use were dated on opening and stored appropriately. Policies and procedures for residents self-administering medications are in place and this includes ensuring residents are competent, and the safe storage of medications. There were three residents self-administering medications on the day of the audit. All processes on managing residents who self-medicate have been completed.  Medication reconciliation is conducted by the nursing team when a resident is transferred back to the service from the hospital or any external appointments. The nursing team checks medicines against the prescription, and these were updated in the electronic medication management system. The GP completes three-monthly reviews. Medication competencies were current, and these were completed in the last 12 months for all staff administering medicines. Medication incidents were completed in the event of a drug error and corrective actions were acted upon.  There were no expired or unwanted medicines and expired medicines are returned to the pharmacy promptly. There is only one medication room. Monitoring of medicine fridge and medication room temperatures is conducted regularly; however, not all deviations from normal had corrective actions documented.  The RN was observed administering medications safely and correctly. Medications were stored safely and securely in the trolley, locked treatment room, and cupboards.  There were no standing orders in use. The medication policy clearly outlines RN responsibilities around supporting residents, including Māori residents and their whānau, to understand their medications. There were no barriers identified to prevent any residents accessing advice or medications. Sixteen electronic medication charts were sampled. All had photograph identification, allergies were documented, and all medications were prescribed and administered appropriately. |
| Subsection 3.5: Nutrition to support wellbeing  The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people’s nutrition and hydration needs are met to promote and maintain their health and wellbeing. | FA | The kitchen service complies with current food safety legislation and guidelines. There is an approved food control plan for the service which expires on 22 March 2025. Meal services are prepared on site and served in the two main dining rooms in both wings. Food is transported using a food hot box cart to the residents in the other wings and rooms. The menu has been reviewed by the registered dietitian.  Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutrition profile developed on admission which identifies dietary requirements, likes, and dislikes. Alternatives are available and all cultural preferences are accommodated. The residents’ weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night when required.  The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Records of temperature monitoring of food, fridges, and freezers are maintained.  All decanted food had records of use-by dates recorded on the containers and no expired items were sighted. The cook reported that residents are offered varied menu options, and these would be culturally specific to te ao Māori where required. A specific Māori menu is available on request.  The residents and family/whānau interviewed indicated satisfaction with the food service. |
| Subsection 3.6: Transition, transfer, and discharge  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. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. 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. | FA | There is a documented process for the management of transfers and discharges. A standard transfer form from Health New Zealand - Waitematā is utilised when residents are required to be transferred to a public hospital or another service. 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. Upon discharge, current and old notes are collated and stored in a locked cupboard in a secure area. If a resident’s information is required by subsequent GP or service, a written request is required for the file to be transferred. Residents are supported to access or seek a referral to other health and/or disability service providers and social support or Kaupapa Māori agencies, where indicated or requested.  Evidence of residents who had been referred to other specialist services such as podiatrists, gerontology nurse specialists, and physiotherapists was sighted in the files reviewed. EPOA/whānau/family are involved in all exits or discharges to and from the service and there was sufficient evidence in the residents’ records to confirm this. |
| Subsection 4.1: The facility  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. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. 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. | FA | The building has a current building warrant of fitness in place expiring 3 November 2023. There is a maintenance contractor who attends as required for preventative and reactive maintenance tasks. Hot water temperatures are taken by the facility manager and were all noted to be within acceptable safe limits. All electrical equipment has been tested and tagged and clinical equipment has had functional checks/calibration undertaken annually. Care staff interviewed stated they had adequate equipment for the safe delivery of care, including weighing scales; pressure prevention mattresses; electric beds with high-pressure rating mattresses; and lazy boy chairs on wheels.  The facility vehicle has a current registration and warrant of fitness.  The communal areas at the service include the two big lounges adjacent to each other at the entrance, and a dining area next to the kitchen. The communal areas are easily and safely accessible for residents. The facility has sufficient space for residents to mobilise using mobility aids and residents were observed moving around freely. There are quiet, low stimulus areas that provide privacy when required. The corridors are wide with handrails. The external areas are well maintained and there is safe access to the outdoor areas. There is an outdoor seating area.  There are sufficient numbers of accessible bathroom and toilet facilities throughout the facility. This includes fourteen rooms with toilet/shower ensuite; nineteen rooms with a toilet; twelve which share a toilet with another resident; six rooms with shared ensuite; and six with no facility. Communal toilet facilities have a system that indicates if it is engaged or vacant and all have locking facilities, Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning; with all toilets, showers, and utility areas having non-slip vinyl flooring. Residents interviewed confirmed their privacy is assured when staff are undertaking personal care.  All residents’ rooms are single. Residents’ rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids for residents. Residents are encouraged to personalise their bedrooms, as observed during the audit. All bedrooms have a hand basin and free-flowing soap and paper towels in the toilet areas. All bedrooms and communal areas have ample natural light and ventilation. All rooms have wall heaters and electric fans are used. Staff and residents interviewed, stated heating and ventilation within the facility are effective.  The service has no immediate plans to change the environment and is aware of their responsibilities around consultation with Māori should there be any major refurbishments, restructuring or building projects planned in the future. |
| Subsection 4.2: Security of people and workforce  The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event. | FA | Plans and policies are in place for civil defence emergencies and described procedures to follow. Adequate supplies for use in the event of a civil emergency meet the National Emergency Management Agency recommendations for the region. There is a register that is maintained that details the care needs of residents in the event of an emergency. Staff have been trained and know what to do in an emergency. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. A trial evacuation drill was performed last on 14 May 2024. The drills are conducted every six months, and these are added to the training programme. The staff orientation programme includes fire and security training.  There are adequate fire exit doors, and the car park is the designated assembly point. All required fire equipment is checked within the required timeframes by an external contractor. A civil defence plan was in place. Adequate supplies in the event of a civil defence emergency, including food, water, candles, torches, continence products, and a gas BBQ were sighted. There is no generator on site; however, the service has written agreements, and work is underway to place a permanent generator on site. Emergency lighting is available and is regularly tested. All staff had current first aid certificates. Staff confirmed their awareness of the emergency procedures.  The service has a call bell system in place that is used by the residents, family/whānau and staff members to summon assistance. All residents have access to a call bell, and these are checked monthly by the maintenance contactor. Residents and family/whānau confirmed that staff respond to calls promptly.  Appropriate security arrangements are in place. Doors are locked at a predetermined time and there is a closed-circuit television and video (CCTV) system monitoring the entrance, rear area, and communal areas. Family/whānau and residents know the process of alerting staff when in need of access to the facility after hours.  There is a visitors' policy and guidelines available to ensure resident safety and wellbeing are not compromised by visitors to the service. Visitors and contractors are required to sign in and out of visitors’ registers. |
| Subsection 5.1: Governance  The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern. | FA | Infection prevention and control and antimicrobial stewardship (AMS) are an integral part of the business plan and objectives of the quality and risk management plan. Infection prevention and control data is collated monthly; however, has not always been reported to the staff meetings (link 2.2.4), and there is no evidence of infection data reporting to the director (link 2.1.4). There is a clear pathway in place for reporting infection prevention and control and AMS issues (such as outbreaks) through the clinical manager, the facility manager, and to the director. Internal benchmarking does not currently occur. There was no evidence in the reports sighted to the director that included internal infection data benchmarking (link 2.2.3).  There are policies and procedures in place to manage significant infection prevention and control events. Any significant events are managed using a collaborative approach and involve the management team, the general practitioner, and the public health team.  External resources and support are available through external specialists, microbiologist, the general practitioner, wound nurse, and Health New Zealand - Waitemata when required.  A registered nurse is the infection prevention and control coordinator who is supported by the clinical manager. A documented infection prevention and control coordinator role description is not on the RN’s file (link 2.4.2). There are adequate resources to implement the infection prevention and control programme at Anne Maree Court. |
| Subsection 5.2: The infection prevention programme and implementation  The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. 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. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services. | FA | The infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention and control and AMS programmes are linked to the quality and business plan. The current programme was implemented in October 2023 and due for next review in October 2024.  Documented policies and procedures are in place and reflect current best practice relating to infection prevention and control and include policies for hand hygiene; aseptic technique; transmission-based precautions; prevention of sharps injuries; prevention and management of communicable infectious diseases; management of current and emerging multidrug-resistant organisms (MDRO); outbreak management; single use items; healthcare acquired infection (HAI); and the built environment.  Infection prevention and control resources, including personal protective equipment (PPE), were available should a resident infection or outbreak occur. Staff were observed to be complying with the infection prevention and control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures. Anne Maree Court has a comprehensive pandemic response plan in place. The infection prevention and control coordinator has input when infection prevention and control policies and procedures are reviewed.  The infection prevention and control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection prevention and control training is included in the mandatory in-services that are held for all staff. Staff have completed cultural training; however, have not completed infection control education in the last 12 months (link 2.3.4). The infection prevention and control coordinator has access to an online training system with resources, guidelines, and best practice; however, the infection prevention and control coordinator has not completed infection control or environmental internal audits as scheduled (link 2.2.2).  The facility manager and infection prevention and control coordinator have responsibility for purchasing consumables. There is a policy in place for decontamination of reusable medical devices and this is followed. Reusable medical equipment is cleaned and disinfected after use and prior to next use. Aseptic techniques are promoted through hand hygiene, and sterile single use wound packs for wound management and catheterisations. Educational resources in te reo Māori are accessible and available. All residents are included and participate in infection prevention and control. |
| Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation  The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services. | FA | There are approved policies and guidelines for antimicrobial prescribing. The antimicrobial policy is appropriate for the size, scope, and complexity of the resident cohort. Infection rates are monitored monthly and reported to the staff meeting. Prophylactic use of antibiotics is not considered to be appropriate and is discouraged. Antibiotic use is reviewed monthly and reported at staff meeting; however, there is no evidence of any trends being identified (link 2.2.4).  Prescribing of antimicrobial use is monitored, recorded, and analysed by the service and the general practitioner. The service monitors antimicrobial use through evaluation and monitoring of medication prescribing charts, prescriptions, and medical notes. |
| Subsection 5.4: Surveillance of health care-associated infection (HAI)  The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. 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. | PA Low | Surveillance is an integral part of the infection control programme. The purpose and methodology are described in the infection control policy in use at the facility. The infection prevention and control coordinator (registered nurse) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the service.  Infections are entered into the infection register on the electronic resident management system. Monthly infection data is collected for all infections based on standard definitions; however, infection control data is not always analysed, benchmarked and evaluated monthly or annually (link 2.2.2). Trends are not identified and analysed; therefore, corrective actions are not always established related to trends. There is no evidence of implementation of quality improvements as indicated. The number of infections occurring each month is tabled at the staff meetings (link 2.2.2). For the meetings that have been held, meeting minutes are available to staff. Infection control surveillance is not reported to governance (link 2.1.4). Ethnicity data is not included in the reporting process of infections.  Staff are made aware of new infections at handovers on each shift, progress notes and clinical records. Short-term care plans are developed to guide care for all residents with an infection. There are processes in place to isolate infectious residents. The service receives email notifications and alerts from Health New Zealand – Waitemata for any community concerns. All communications were observed to be culturally appropriate.  Education for residents regarding infections occurs on a one-to-one basis and includes advice and education about hand hygiene, medications prescribed and requirements if appropriate for isolation. There have been no outbreaks since last audit. There are documented processes related to outbreak management which staff are aware of as demonstrated during interviews. Systems are in place to ensure residents and family/whānau are updated regularly during outbreaks.  Hand sanitisers and gels are available for staff, residents, and visitors to the facility. |
| Subsection 5.5: Environment  The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. 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. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms. | FA | Waste management policies are in place and confirm to legislative and local council requirements. Policies include considerations of staff orientation and education; incident/accident, and hazards reporting; use of PPE; and disposal of general, infectious, and hazardous waste.  Current material safety data information sheets are available and accessible to staff in relevant places in the facility, such as the sluice rooms, and laundry/cleaner’s room. There is no evidence to demonstrate that staff have received training and education in waste management and infection prevention and control, as components of mandatory training (link 2.3.4).  Interviews and observations confirmed that there is enough PPE and equipment provided, such as aprons, gloves, and masks. Interviews confirmed that the use of PPE is appropriate to the recognised risks. Observation confirmed that PPE was used in high-risk areas. There are sluice rooms, with sanitisers and adequate supplies of PPE, including eye wear.  Cleaning services are provided seven days a week. Cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. Household staff are aware of the requirement to keep their cleaning trolleys in sight and were observed doing this during the audit. Chemical bottles/cans in storage and in use were noted to be appropriately labelled. There is no evidence to demonstrate that household staff have completed chemical safety training (link 2.3.4).  All laundry is processed on site. The safe and hygienic collection and transport of laundry items into relevant colour containers was witnessed. The infection prevention and control coordinator monitors cleaning and laundry services; however, there is no evidence that infection prevention and control internal audits have been completed as scheduled (link 2.2.2). Residents and family/whānau confirmed satisfaction with laundry services in interviews, and in satisfaction surveys reviewed at the time of the audit. Any concerns that arise are immediately addressed.  There is a policy to provide direction and guidance to safely reduce the risk of infection during construction, renovation, installation, and maintenance activities. It details consultation by the infection prevention and control coordinator. There was no construction, installation, or maintenance in progress at the time of the audit. |
| Subsection 6.1: A process of restraint  The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination. | PA Low | The restraint policy states, ‘The company is committed to providing services to all residents without use of restraint.’ The restraint coordinator reported they work in partnership with Māori as they do with all residents to ensure services are mana enhancing and use least restrictive practices. The CM and FM on interview described the focus on working towards a restraint-free environment.  There is a process of reporting to the facility manager and owner director; however this was not evidenced in reports (link 2.1.4). The owner director is involved in the service on a regular basis and supports the management team on eliminating any restraint use. Restraint use is part of the quality data collated, which is reported at all levels of the service.  The restraint coordinator is the RN for which there is a job description. The restraint coordinator monitors environmental impacts on the use of restraint and implements changes that contribute to restraint minimisation. An example of this is the use of low-low beds and fall out mats. The clinical/staff group meet monthly, and restraint usage is discussed at this meeting. There are currently five residents utilising a restraint (three lap belts, and two bed rails). The restraint management policy and procedure inform the delivery of services to avoid the use of restraint. The use of alternative methods is a focus of the policy. The policy includes holistic assessment processes of the person, support plan, and information on avoiding the use of restraint.  Restraint elimination training is included as part of the annual mandatory training plan orientation booklet and annual restraint competencies are scheduled; however have not always occurred as planed (link 2.3.4). All staff have current restraint competencies. The service is working towards having a resident or representative with lived experience on the restraint committee. |
| Subsection 6.2: Safe restraint  The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first. Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort. As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort. | PA Low | The restraint committee has determined and approved the following restraint equipment types, which includes bedrails, chair lap belt and fall out chair. Restraint is only initiated and as a last resort after consultation with a GP, registered nurse and restraint coordinator and involve the resident and/or their next of kin/representative. There is an implemented process describing the frequency and extent of monitoring restraint that relates to identified risks.  The assessment process includes alternatives and identifies interventions and strategies that have been tried or implemented. There are five residents identified on the restraint register. Restraint assessments had been completed which linked to the care plan. The care plan included interventions to manage the resident’s safety and dignity. Monitoring requirements are identified in the care plan. Records reviewed identified the regular two-hourly monitoring while restraints are in place. Progress notes describe restraint events. The restraint use is evaluated monthly. The resident and family/whānau are involved in the review.  The restraint policy includes clear guidelines around the use of emergency restraint. The policy states a full review of each restraint incident will be completed, and the report forwarded to the restraint coordinator/CM for consideration. There has been one reported event of emergency restraint at Anne Maree Court; however, there was no evidence of a debrief meeting held following the use of the emergency restraint. |
| Subsection 6.3: Quality review of restraint  The people: I feel safe to share my experiences of restraint so I can influence least restrictive practice. Te Tiriti: Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions. As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities. | FA | The service is working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities. The service includes the use of restraint in their annual internal audit programme. The outcome of an internal audit goes through to the restraint coordinator, CM, and the staff meetings when held. The restraint coordinator, CM, and FM meet six-monthly and includes a review of restraint use, restraint incidents, and education needs. Restraint data, including any incidents, are reported as part of the RN report to the CM and FM. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.6.3  My service provider shall practise open communication with me. | PA Low | Policies and procedures relating to accident/incidents, complaints, and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. All communication with family/whānau is documented in the resident’s file; however, for four of the 12 events reviewed in the electronic register, there was no evidence of family/whānau being notified of the events either on the incident forms, progress notes or via emails. | There is no documented evidence of family/whanau being consistently notified following adverse events. | Ensure that family/whānau are notified following adverse events.  60 days |
| Criterion 1.8.3  My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers’ Rights. | PA Low | In the event of a complaint, documentation including follow-up letters and resolution, would be completed, and managed in accordance with guidelines set by the Health and Disability Commissioner. There have been two documented complaints in the register. Interview with residents confirmed that there were two different complaints raised; however, these were not sighted in the complaints register on the day of the audit. One of the complaints resulted in a meeting facilitated by the facility manager between the resident and a staff member, which on interview with the facility manager confirmed had occurred but there was no documented record of the complaint and processes followed. | Interview with residents confirmed that they had raised verbal complaints on two different occasions; however, there was no documented evidence of records of the complaints in the register. | Ensure there are documented records of all complaints raised (verbal or written).  90 days |
| Criterion 2.1.4  Governance bodies shall evidence leadership and commitment to the quality and risk management system. | PA Low | The director and facility manager have monthly meetings, and the director visits the facility at least twice a month and is available via email or over the phone as and when required. However, review of the monthly facility manager’s report to the director does not evidence incorporation of all quality and risk issues. | Monthly facility manager reports to the director are not documented consistently to incorporate all quality and risk issues including infection control and restraint. | Ensure there is consistent incorporation of all quality and risk issues to the director.  90 days |
| Criterion 2.2.2  Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care. | PA Moderate | Internal audits, meetings, and collation of data were not taking place as scheduled. Since last audit the service has only completed audits comprehensively in May and June 2024 and none in the other months have been fully completed. Where corrective actions were identified in meeting minutes there was no evidence of follow-up and sign off when completed. Resident and staff satisfaction surveys have been completed for 2024 but there is no evidence of collation and analysis of results to inform quality improvements. | (i). Internal audits including medication, cleaning, laundry, maintenance, continence, health and safety, privacy, chemical safety, staff files, culture, wound care and skin, kitchen have not been evidenced as being completed as scheduled.  (ii). There is no evidence of follow-up of actions from meetings and sign off when completed.  (iii). There is no evidence of collation and analysis of results from residents and staff satisfaction surveys to inform quality improvements. | (i). Ensure internal audits are completed as scheduled.  (ii). Ensure corrective actions are followed up and signed off when completed.  (iii). Ensure results of satisfaction surveys are collated and analysed.  60 days |
| Criterion 2.2.3  Service providers shall evaluate progress against quality outcomes. | PA Moderate | Quality data related to incidents and infections that occurred each month was documented in the staff meeting minutes and posted for staff to see. However, there was no evidence of quality data and trends in data being analysed and implementation of quality improvements as indicated. | There is no evidence of analysis of incidents, accidents and infections, implementation of quality improvements and evaluation of actions to ensure continuous quality improvement of service delivery. | Ensure there is evidence of analysis of incidents, accidents and infection, implementation of quality improvements and evaluation of actions to ensure continuous quality improvement of service delivery.  60 days |
| Criterion 2.2.4  Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them. | PA Moderate | The staff meetings provide an avenue for discussions in relation to (but not limited to): quality data; health and safety; infection control/pandemic strategies; complaints received (if any); cultural compliance; internal audit compliance; staffing; and education. However, the staff meetings have not been completed as scheduled. Since last audit, staff meetings have only been completed in June, April and January 2024. There was no evidence of key risk areas being discussed. The minutes reviewed would show the risk such as restraint identified as a standing agenda for discussions, however, there was no documentation evidencing discussions around the risk to identify how many residents were restrained, type of restraints, any incidents, training or audits related to restraints. This pattern of failure to evidence discussion was evident with other risk topics like infections, incidents, education and internal audits. Resident meeting are scheduled to be completed every three months. These have only been completed in January and April 2024 since last audit. For the minutes reviewed where actions were raised, there was no evidence that these were followed up and signed off when completed. | (i). Staff meeting have not been evidenced as occurring as scheduled.  (ii). Meeting minutes reviewed do not evidence discussion, and analysis of key risk areas such as restraints, infections, adverse events and internal audits.  (iii). Resident meeting minutes have not been completed as scheduled.  (iv). There is no evidence to show that issues raised in resident meetings have been actioned and signed off when completed | (i). Ensure that meetings are completed as scheduled.  (ii). Ensure there is evidence in the minutes of discussion, and analysis of key risk areas such as restraints, infections, adverse events and internal audits.  (iii). Ensure resident meetings are completed as scheduled.  (iv). Ensure issues raised in resident meetings are actioned and signed off when completed  60 days |
| Criterion 2.2.6  Service providers shall understand and comply with statutory and regulatory obligations in relation to essential notification reporting. | PA Moderate | Discussions with the facility manager and clinical manager reflected their awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been one WorkSafe notification completed in June 2024 and one section 31 notification related to resident behaviour that involved the police. However, at the time of the audit there was no evidence to demonstrate that section 31 notifications were completed at the time of appointment of the facility manager and clinical manager into their roles. | There is no evidence to demonstrate that section 31 reporting for facility manager and clinical manager appointment were completed. | Ensure that statutory and regulatory obligations in relation to essential notification reporting is completed  90 days |
| 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. | PA Low | There is a staffing policy, with a staff and contingency shortfall plan which describes rostering requirements. The roster provides sufficient and appropriate cover for the effective delivery of care and support. Anne Maree Court have a full complement of registered nurses to provide a 24/7 cover. The two-week rosters reviewed evidence that six unplanned absence that were not covered or backfilled. This includes mainly the healthcare assistant shifts. | There is no evidence to demonstrate cover or backfill for six unplanned absences during the two week roster reviewed at the time of audit. | Ensure backfill or cover for unplanned absences on the roster  90 days |
| Criterion 2.3.4  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. | PA Low | There is an annual education and training schedule in place. The education and training schedule lists compulsory training which includes cultural awareness training. External training opportunities for care staff include training through Health New Zealand - Waitakere and hospice. However, there is no documented evidence that staff have completed training as scheduled with the exception of cultural awareness, privacy and emergency evacuation. | There are no records to evidence that training including falls prevention, skin care and wound management, challenging behaviour, abuse and neglect, code of right, Treaty of Waitangi, restraints, infection control, chemical safety, complaints, communication, health and safety has been completed by staff to meet standards and contractual requirements. | Ensure that staff complete the required training and there are documented records to evidence this.  90 days |
| Criterion 2.4.2  Service providers shall ensure the skills and knowledge required of each position are identified and the outcomes, accountability, responsibilities, authority, and functions to be achieved in each position are documented. | PA Low | Job descriptions are in place for all positions and cover outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. However, these were not always available in the files reviewed. Of the six staff files two did not have job descriptions in place. Although the registered nurse had a signed job description for their registered nurse role on file, they did not have one for infection prevention and control coordinator role. | i). There was no signed job descriptions for the cook and one HCA.  ii). There was no job description in place for the infection prevention and control coordinator role. | Ensure that signed job descriptions are on staff files.  90 days |
| Criterion 2.4.4  Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided. | PA Low | Human resource policies are in place, including recruitment, selection, orientation, and staff training and development. Of the six files reviewed three did not have any documented evidence of orientation and for one there was an orientation manual; however, there were so many sections not completed or signed off in the manual. | There is no evidence of documented orientation for the cook and the clinical manager. | Ensure that there is documented evidence of orientation for all new staff.  90 days |
| Criterion 3.2.1  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. | PA Moderate | There is a policy and process determining resident assessment and care plan timeframes. All assessments and care plans have been developed and evaluated by a RN in partnership with the resident and family/whānau; however, not all were completed within the required 21 days, and not all care plans had ben reassessed within six months. | (i). Two care plans and three interRAI assessments were not completed within 21 days of resident admission.  (ii). Three interRAI assessments had not been reviewed within the 6-month timeframe. | (i). & (ii). Ensure care plans and all assessments and reassessments are completed within the required timeframes.  60 days |
| Criterion 3.2.3  Fundamental to the development of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people’s lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people’s values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a person’s wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People’s care or support plan identifies wider service integration as required. | PA Low | There is a policy and process determining resident assessment and care plan content. Care plans are holistic in nature and include cultural preferences; however, not all care plans contained sufficient interventions or content to guide staff in the safe care of residents’ conditions. | Three of eight resident care plans did not include appropriate interventions or guidance for staff to manage restraint and conditions including challenging behaviour, diabetes, suprapubic catheter, and autonomic dysreflexia. | Ensure care plans are sufficiently detailed to guide staff in the safe care and management of resident’s needs and medical conditions.  60 days |
| Criterion 3.2.4  In implementing care or support plans, service providers shall demonstrate: (a) Active involvement with the person receiving services and whānau; (b) That the provision of service is consistent with, and contributes to, meeting the person’s assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective; (c) That the person receives services that remove stigma and promote acceptance and inclusion; (d) That needs and risk assessments are an ongoing process and that any changes are documented. | PA Moderate | There are a suite of monitoring charts available for RNs and staff to utilise. The monitoring charts reviewed including (but not limited to) vital signs, weight etc have all been completed as instructed in the care plans. There is a falls policy that states a requirement for neurological observations being undertaken for unwitnessed falls or where there is suspected injury to the head; however, not all neurological observations had been evidenced as being completed as per policy. | Five out of six fall related incidents did not have neurological observations completed as per policy. | Ensure neurological observations are completed as per policy.  60 days |
| Criterion 3.4.1  A medication management system shall be implemented appropriate to the scope of the service. | PA Moderate | There is a policy and process for safe medication storage including temperature monitoring. Monitoring of medicine fridge and medication room temperatures is conducted regularly; however, not all deviations from normal had corrective actions documented. | Eight medication fridge temperatures during August were outside of the acceptable range without their being any documented corrective actions. | Ensure corrective actions are carried out to ensure medication fridge temperatures remain within the safe and acceptable range  60 days |
| Criterion 5.4.3  Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data. | PA Low | Infections are entered into the infection register on the electronic resident management system. The infection prevention and control coordinator collects the monthly infection data based on standard definitions and tables this at the staff meeting. Ethnicity data is not included in the reporting process of infections. | Infection surveillance does not currently include ethnicity data. | Ensure infection surveillance includes ethnicity data.  90 days |
| Criterion 6.1.2  Service providers shall demonstrate a commitment to ensuring the voice of people with lived experience, Māori and whānau, is evident on the restraint oversight groups. | PA Low | The service does not have a process or policy for ensuring the voice of people with lived experience, Māori and whānau, is evident on the restraint oversight groups. | There is not currently a resident or representative with lived experience on the restraint committee. | Ensure a person with lived experience is evident on the restraint oversight group.  90 days |
| Criterion 6.2.5  A person-centred debrief shall follow every episode of emergency restraint. Participation in this debrief shall be determined by the person when they feel ready. | PA Low | There is a process detailing the requirement for a person-centred debrief following an episode of emergency restraint; however, this did not occur following such an episode. | An episode of emergency restraint occurred without a person-centred debrief following the event. | The service will ensure a person-centred debrief shall follow every episode of emergency restraint.  90 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this audit.

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End of the report.