Living Waters Medical Solutions Limited - Springvale Manor

Introduction

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

The audit has been conducted by 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.

The specifics of this audit included:

Legal entity:	Living Waters Medical Solutions Limited
Premises audited:	Springvale Manor
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 17 October 2024 End date: 18 October 2024

Proposed changes to current services (if any): None.

Total beds occupied across all premises included in the audit on the first day of the audit: 27

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

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

General overview of the audit

Springvale Manor is located in Whanganui. The service is certified to provide rest home and dementia level care for up to 27 beds. There were 27 residents on the days of the audit.

This surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Services Standard 2021 and the services contract with Health New Zealand - Te Whatu Ora. The audit process included a review of quality systems, the review of residents and staff files, observations, and interviews with residents, family/whānau, staff, management, and a general practitioner.

Springvale Manor has set several quality goals which link to the organisation's business plan. The directors have experience in the aged care sector and are supported by the facility manager and the clinical nurse lead (registered nurse). Feedback from residents and families was very positive about the care and the services provided.

The areas for improvement identified at the previous audit relating to internal audits; incident / accident management; education programme; care plan evaluations; Māori care plans; medication room temperature monitoring, 'as required' medication effectiveness; preventative maintenance plans; access to outdoor space; fire exit access; and restraint assessments have been satisfied.

Improvements are still required in relation to fire evacuation plan; medication management; implementation of care plans including interventions, assessments and timeframes.

This surveillance audit identified areas for improvement related to consent process; complaints management; implementation of the quality and risk management system; staff competencies; implementation of food control plan; and outbreak management.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Some subsections applicable to this service partially attained and of low risk.

Springvale Manor provides an environment that supports resident rights and safe care. There is a Māori health plan in place for the organisation. Te Tiriti O Waitangi is embedded and enacted across policies, procedures, and delivery of care. The service recognises Māori mana motuhake and this is reflected in the Māori health plan and business plan. A Pacific health plan is in place which ensures cultural safety for Pacific peoples, embracing their worldviews, cultural, and spiritual beliefs.

Springvale Manor demonstrates their knowledge and understanding of resident's rights and ensures that residents are informed in respect of these. Staff provide services and support to people in a way that is inclusive and respects their identity and their experiences. Residents are kept safe from abuse, and staff are aware of professional boundaries. There are established systems to protect resident's property and finances.

The rights of the resident and/or their family/whānau to make a complaint is understood, respected, and upheld by the service in accordance with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, and complainants are kept fully informed.

Hunga mahi me te hanganga | Workforce and structure

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 2024 business plan includes specific and measurable goals that are reviewed. The service has quality and risk management systems that include quality improvement initiatives and monitoring. Internal audits and the collation of clinical indicator data were documented as taking place, with corrective actions as indicated. Hazards are identified with appropriate interventions implemented.

A recruitment and orientation procedure is established. Caregivers are buddied with more experienced staff during their orientation. There is a staffing and rostering policy. A staff education/training programme is being implemented.

Ngā huarahi ki te oranga | Pathways to wellbeing

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.

The registered nurses are responsible for the assessment, development, and evaluation of care plans. Evaluations were completed in the care plans reviewed.

The organisation uses an electronic medicine management system for e-prescribing and administration of medications. The general practitioner is responsible for all medication reviews. Staff involved in medication administration are assessed as competent to do so.

The food service caters for residents' specific dietary likes and dislikes. Nutritional snacks are available for residents 24 hours.

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

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

There is a current building warrant of fitness. There is a planned and reactive maintenance programme in place.

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

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.

An infection control programme is documented for the service. Staff have attended education around infection control.

Surveillance of health care-associated infections is undertaken, and results are shared with all staff. Follow-up action is taken as and when required. There have been two outbreaks since the previous audit in July 2023.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service fully attained.

The service is committed to maintaining a restraint-free service. This is supported by the governing body and policies and procedures. There were residents using restraints at the time of the audit. Staff interviewed demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques and alternative interventions to minimise the use of restraint.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	10	0	5	4	0	0
Criteria	0	44	0	5	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.

For more information on the different types of audits and what they cover please click here.

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	There is a documented commitment to recognising and celebrating tāngata whenua in a meaningful way through partnerships, educational programmes, and employment opportunities. The Māori health plan references local Māori health care providers and shows recognition of Māori values and beliefs. The plan acknowledges Te Tiriti o Waitangi as a founding document for New Zealand. There are residents who identify as Māori. A Māori family member (interviewed) confirmed that mana motuhake is recognised. At the time of the audit, there were Māori staff. Staff have completed training around cultural safety and Te Tiriti o Waitangi.
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	FA	Springvale Manor has a Pacific health plan and cultural policy that encompasses the needs of Pasifika and upholds the principles of Pacific people by acknowledging respectful relationships, embracing cultural and spiritual beliefs and providing high quality healthcare. At the time of the audit there were no Pasifika residents. There were Pasifika staff.

for improved health outcomes.		
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, sign language and te reo Māori. The clinical nurse lead (interviewed) demonstrated how it is also provided in welcome packs in the language most appropriate for the resident to ensure they are fully informed of their rights. One resident interviewed (rest home) and five family/whānau (one rest home and four dementia) reported that all staff respected their rights, and that they were supported to know and understand their rights. Care plans reviewed were resident centred. Staff have completed training on the Code.
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. Springvale Manor policies prevent any form of discrimination, coercion, harassment, or any other exploitation. The staff code of conduct addresses harassment, racism, and bullying. Staff sign to acknowledge that they accept the code of conduct as part of the employment process. Staff complete education on orientation and annually as per the training plan on how to identify abuse and neglect. Staff are educated on how to value the older person, showing them respect and dignity. All residents and families/whānau interviewed confirmed that the staff are very caring, supportive, and respectful. The service implements a process to manage residents' comfort funds, such as sundry expenses. Professional boundaries are defined in job descriptions. Interviews with the clinical nurse lead (registered nurses) and caregivers confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation. Interviews with seven staff (three caregivers, one clinical nurse lead, one maintenance, one team leader [administrator] and one cook), one facility manager, residents and family/whānau and documentation reviewed, confirmed that the staff are very caring, supportive, and respectful.

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.	PA Low	There are policies documented around informed consent. Staff and management have a good understanding of the process to ensure informed consent for all residents (including Māori, who may wish to involve whānau for collective decision making). Five resident files were reviewed; however not all had signed general consents and admission agreements on file as part of the admission process. Specific consent forms had been signed by residents or their activated enduring power of attorney (EPOA) for procedures, such as vaccines and other clinical procedures. Interviews with family whānau and residents confirmed their choices regarding decisions and their wellbeing is respected.
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 families/whānau during the resident's entry to the service. Access to complaints forms is located at the entrance and in the admission pack or on request from staff. Residents or relatives making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and complaints process is visible, and available in te reo Māori, and English. A complaints register is maintained which includes all complaints and dates; however, for the one internal complaint that was logged since last audit, there was no evidence of supporting documents including (but not limited to) complaint acknowledgement letters, investigations, meetings and outcome letters. The HDC complaint from the previous audit remains open with all required information submitted by Springvale Manor as requested by HDC. An interview with the clinical nurse lead and team leader, and review of documentation demonstrated that complaints are not managed in accordance with guidelines set by the HDC. Discussions with residents and family/ whānau confirmed that they were provided with information on the

		complaints process and remarked that any concerns or issues they had, were addressed promptly. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. Interpreters contact details are available. The clinical nurse lead acknowledged their understanding that for Māori, there is a preference for face-to-face communication and to include whānau participation. Staff interviewed confirmed they are informed of complaints (and any subsequent corrective actions) in staff meetings.
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.	FA	Springvale Manor is part of Living Waters Medical Solutions Limited, located in Whanganui. The provider also owns another aged care facility nearby that provides 21 care beds. Springvale Manor provides rest home and dementia level of care for up to 27 residents. There were 27 residents at the time of the audit: five rest home level including one on intermediate care and 22 dementia level. All the remaining residents were on the aged related residential care contract (ARRC). Springvale Manor has a business plan (2024) in place, which links to the Living Waters Medical Solutions Limited's vision, mission, values, and strategic direction. Clear specific business goals are documented to manage and guide quality and risk and are reviewed. The Springvale Manor business plan was reviewed in January 2024. There is a managing director (owner) who took ownership of Springvale Manor in 2022 and oversees the operations of the two facilities. The director has extensive business experience and understands their responsibility in the implementation of health and disability services standard and the organisations commitment to Te Tiriti obligations. The obligation to proactively help address barriers for Māori and to provide equitable health care services is documented in the Business Plan. The Māori Health plan reflects a leadership commitment to collaborate with Māori and aligns with the Ministry of Health strategies. The managing director is supported by and works closely with the facility manager and the clinical nurse lead (registered nurse) to ensure management of the service is in keeping with the relevant standards and legislation. The clinical nurse lead (registered nurse) provides clinical oversight for the facility. The clinical nurse lead, working alongside the

		registered nurse from the sister facility, the managing director, and the facility manager provide the clinical governance across the two facilities. The working practices at Springvale Manor are holistic in nature, inclusive of cultural identity, spirituality and respect the connection to family/whānau and the wider community. There is a communication policy that addresses meeting requirements and communication between management, staff, residents and family/whānau. Interviews with family/whānau stated they are informed of what is happening within the facility and the care of their whānau through phone calls and face to face interactions with clinical nurse lead (registered nurse). The facility manager oversees the implementation of the business strategy, quality plan, at Springvale Manor. The facility manager and clinical nurse lead (registered nurse) meet regularly with the managing director to discuss progress updates on various topics including quality data analysis, escalated complaints, human resource matters and occupancy. The facility manager and clinical nurse lead (registered nurse) are supported by a team leader (administrator) and experienced caregivers. The clinical nurse lead (registered nurse) provides clinical on call cover 24/7 and any operational issues are escalated to the facility manager. The facility manager and clinical nurse lead have both completed more than eight hours of professional development in the last 12 months related to managing a rest home and looking after the older person.
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	PA Moderate	Springvale Manor has an implemented quality and risk management programme, developed by an external contractor. The quality system includes performance monitoring through internal audits; resident, family/whanau satisfaction; staff retention; and the collection, collation, and comparison of clinical indicator data. Monthly 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; staffing; and education. Internal audits, meetings, and collation of data were verified as taking place, with corrective actions documented where indicated to address service improvements, with evidence of progress and sign off when achieved. This is an improvement on the previous audit, and the partial attainment relating

health care and support workers.		to HDSS:2021 # 2.2.1 has been satisfied. Quality and risk goals and progress towards attainment are discussed at meetings. Quality data and trends are added to meeting minutes and available for staff to access in the nurses' stations. Corrective actions are discussed at staff meetings to ensure any outstanding matters are addressed with sign off when completed. The facility manager, clinical nurse lead and team leader have weekly meetings with the managing director ensuring governance remain fully informed of all key performance indicators, HR, occupancy, complaints, internal audits results, corrective action progress and general business. The facility manager or the team leader (administrator), the clinical nurse lead and the registered nurse from the sister facility meet monthly providing collegial support and an opportunity to discuss clinical data trends and share improvement ideas. Resident, family/whānau satisfaction surveys are completed annually. The December 2023 resident, family/whānau satisfaction surveys have not been collated and analysed to confirm the level of satisfaction. The results have not been shared with staff, residents and family/ whānau. Three monthly resident, family/ whānau meetings have been completed and provide an opportunity to provide feedback on service delivery. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 2.2.2 has been satisfied. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. Policies are regularly reviewed and have been updated to align with Ngā Paerewa NZS 8134:2021. A document control system is in place. New policies or changes to policy are communicated to staff. A health and safety system is in place. Hazard identification forms are completed, and an up-to-date hazard register was reviewed (sighted). Manufacturer safety datasheets are up to date. Staff are kept informed on health and safety issues in handovers and meetings. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form. Hard copy accident/incident forms are completed for each incident/accident, and immediate action is documented with any follow-up action(s) required,

		evidenced in the accident/incident records reviewed. Each incident involving a resident reflected a clinical assessment and follow up by a registered nurse. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 2.2.2 has been satisfied. Opportunities to minimise future risks were identified where possible through a corrective action plan and discussions at staff meetings. Incident and accident data is collated monthly, analysed for trending and internally benchmarked. Results are discussed at the meetings. Discussions with the clinical nurse lead evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There has been one Health Quality and Safety Commission (HQSC) notification completed in relation to an unstageable pressure injury. There were two Covid-19 outbreaks since the previous audit, which were not appropriately notified (link 5.4.1).
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 that describes rostering. The roster provides sufficient and appropriate coverage for the effective delivery of care and support. The clinical nurse lead (registered nurse), activities staff, and a selection of caregivers hold current first aid certificates. There is a first aid trained staff member on duty 24/7. Interviews with staff confirmed that their workload is manageable, and that management is very supportive. Staff and residents are informed when there are changes to staffing levels, evidenced in staff interviews. The facility manager, team leader (administrator) and clinical nurse lead are available Monday to Friday. Clinical on-call is provided by the clinical nurse lead. The facility manager is available 24/7 for any non-clinical concerns. There is an annual education and training schedule being implemented that includes mandatory training. A record of completion is maintained on staff file records and hard copy training register. The education and training schedule lists compulsory training, which includes Māori health, tikanga, and Te Tiriti O Waitangi. Cultural awareness training is part of orientation and provided annually to all staff. Training to care for dementia residents includes dementia care which incorporates challenging behaviours and de-escalation. External training opportunities for care staff include training through Health New Zealand – Te Whatu Ora. This is an improvement on

		the previous audit, and the partial attainment relating to HDSS:2021 # 2.3.4 has been satisfied. Competencies and questionnaires are completed by staff, which are linked to the education and training programme. Staff completed competency assessments and/or questionnaires as part of their orientation related to cultural competency, fire safety, cultural safety including bias and discrimination, workplace bullying, stigma and racism, infection control, hand hygiene, manual handling, and medication management. These are repeated annually as evidenced in the staff files reviewed, however the clinical nurse lead (registered nurse) did not have current competencies. All care staff who administer medications are required to complete medication competencies annually. The service supports and encourages caregivers to obtain a New Zealand Qualification Authority (NZQA) qualification. Of the 16 caregivers and the diversional therapist, four have completed level 3 and above; eight on level 2 and four on level 0. All the caregivers work in the dementia unit with twelve caregivers having completed the required dementia unit standards; zero caregivers currently enrolled and the remaining four have been employed less than 18 months. Additional registered nurse competencies cover medication administration, interRAI assessment and wound management. The one registered nurse who is the clinical nurse lead is interRAI trained.
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	FA	There are human resources policies in place, including recruitment, selection, orientation, and staff training and development. Staff files are stored securely in the manager's office. Five staff files reviewed (clinical nurse lead [registered nurse], two caregivers, cook and cleaner/laundry staff) evidenced implementation of the recruitment process, employment contracts, police checking and completed orientation programmes specific to their roles. There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, and additional roles (e.g., restraint coordinator, infection control coordinator) to be achieved in each position. All staff sign their job description during their onboarding to the service.

services.		A register of practising certificates is maintained for all health professionals. The appraisal policy is implemented. All staff who had been employed for over one year have an annual appraisal completed. 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.
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	Five resident files were reviewed: two rest home (including one resident on intermediate care) and three dementia level of care. All other residents were under the age-related residential care (ARRC) agreement. The clinical nurse lead, a registered nurse (RN), is responsible for all residents' assessments, care planning and evaluation of care. Care plans are based on data collected during the initial nursing assessments, which include but are not limited to values, beliefs, skin assessment and pressure injury risk, pain, continence, mobility and falls risk, dietary needs, and information from pre-entry assessments completed by the Needs Assessment Service Coordination (NASC) or other referral agencies. Cultural assessments were completed by the registered nurse; however, the RN's cultural competency was overdue for renewal (link 2.3.3). The partial attainment related to HDSS:2021 # 3.2.3 continues. Initial assessments and long-term care plans detailing needs, and preferences for residents were not completed within the required timeframes. The previous audit shortfall (HDSS:2021 # 3.2.1) around assessment timeframes continues. The long-term care plans (LTCPs) are developed with information gathered during the initial assessments and the interRAI assessment. Long-term care plans and interRAI assessments (except for the resident on intermediate care) sampled had not all been completed within three weeks of the residents' admission to the facility. The interRAI assessments, Minimum Data Set (MDS) comments and the assessment summary were kept in the resident file. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 3.2.3 has been satisfied. For the resident on intermediate care (exempted from interRAI assessment) risk assessments were completed that informed the care plan, related to (but not limited to) continence and toileting, dietary needs, mobility, falls risk, and pressure risk.

		Resident and family/whānau communications are recorded in the resident's file (on the family whanau contact form), including interventions around family/whānau support, self-advocacy, and changes to care needs to achieve pae ora goals. This is an improvement from previous audit and the partial attainment related to HDSS:2021 # 3.2.4 has been met. Documented interventions in the LTCPs are not comprehensive enough to meet the residents' assessed needs, and direct comprehensive care delivery. The previous audit shortfall related to HDSS:2021 # 3.2.3 around care plan interventions continues. Residents in the dementia unit did not have behaviour assessments and behaviour plans with associated risks and supports needed, including strategies for managing/diversion of behaviours. The were no 24-hour behaviour care plans that included close to normal routine showing a 24-hour reflection of resident's usual pattern and behaviour management strategies to assist caregivers in management of the resident behaviours. For Māori residents receiving care at the time of the audit, the RN completed a Māori health care plan which described the support required to meet resident's needs. The Māori care plan reviewed had culturally specific documentation and interventions to address individual resident's needs. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 3.2.7 has been satisfied. The RN interviewed, described removing barriers so all residents have access to information and services required to promote independence, however there was no documented evidence of working alongside residents and family/whanau with assessments and when developing care plans. Short term care plans are developed for short term needs such as infections, wounds, bruises, however these have not always been completed for identified short term needs. Long-term care plans are formally evaluated every six months in conjunction with the interRAI re-assessments. Evaluations are documented by the registered nurse. The evaluations include the degree of achievement towards meeting desired goals and outcomes. This is an improvement from previous audit and the partial attainment related to HDSS:2021 # 3.2.5 has been met. The initial medical assessment is not always undertaken within the required timeframe by the contracted general practitioner (GP) following admission. Residents have not always had reviews by the GP within required

		timeframes and when their health status changes. There is documented evidence of the exemption from monthly GP visits when the resident's condition is considered stable. There is a registered nurse prescriber from the contracted GP practice who visits the facility once a week and is available as needed during office hours. The GP and nurse prescriber have access to the medication system and send clinic notes post reviews to be integrated into the resident records. Documentation by the registered nurse prescriber and records reviewed were current. The GP interviewed stated that there was good communication between the registered nurse prescriber and the clinical team at the facility and that the RN demonstrated good assessment skills and that they were informed of concerns in a timely manner. After hours, the facility contacts the local emergency centre for on call support. A physiotherapist, speech language therapist, hospice, wound care nurse specialist and medical specialists are available as required through Health New Zealand – Te Whatu Ora. Contact details for family are recorded in the resident records. Family/whānau interviews and resident records evidenced that family/whānau are informed where there is a change in health, including infections, accidents/incidents, registered nurse prescriber visits and medication changes. There was evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. There were three wounds from three residents being actively managed. These included a skin tear, an ulcer and a self-inflicted injury. Referrals are completed to the wound nurse specialist as clinically indicated. Caregivers interviewed could describe a verbal and written handover at the beginning of each shift that maintains a continuity of service delivery, as observed on the day of audit, and was found to be comprehensive in nature. Progress notes are written each shift and as necessary by caregivers. However, there were no current progress notes by the registered nurse. When changes occur with the residents' health, these are reflected in the progress notes by the caregiver. When a resident's condition alters, the registered nurse initiates a review with the registered nurse prescriber. The registered nurse also undertakes assessments, including (but not limited to) falls risk, pressure risk and pain assessment as required.

		Monthly observations such as weight and blood pressure were completed and are up to date. All resident incidents were evidenced as being followed up in a timely manner by the registered nurse. Interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Neurological observations have routinely been completed for unwitnessed falls or those where head injury was suspected as part of post falls management. Resident care is evaluated on each shift and reported at handover. Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms.
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 are policies available for safe medicine management that meet legislative requirements. Medications are stored safely in a locked room. Caregivers and registered nurses responsible for medication administration complete medication competencies (link 2.3.3). Regular medications and 'as required' medications are delivered in blister packs. The medication competent staff check the packs against the electronic medication chart and a record of medication reconciliation is maintained. Any discrepancies are reported back to the supplying pharmacy. Expired medications, and those for deceased/discharged residents are not always returned to pharmacy in a timely manner. There were no residents self-administering medications on the days of audit. Assessments, reviews, storage, and procedures relating to self-medication is available for residents that may wish to self-administer their medications. Observation of the medication round confirmed that staff were safely administering medications according to expected policy requirements. Controlled drugs are stored in a secure safe in a locked cupboard. Controlled drug stock checks have not been completed weekly by medication competent staff. Signing charts on the electronic medication system include two signatures. Medication fridge and room air temperatures are checked weekly, recorded, and were within the acceptable temperature range. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 3.4.3 has been satisfied. Eye drops were dated on opening and within expiry

		date. Ten electronic medication charts were reviewed and met prescribing requirements. Medication charts had photographic identification and allergy status documented. The general practitioner had reviewed the medication charts three-monthly. All 'as required' medications had prescribed indications for use. The effectiveness of 'as required' medication has been consistently documented in the medication system and progress notes. There was evidence of registered nurse assessment and evaluation of outcomes. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 3.4.3 has been satisfied. Standing orders are not in use. All medications are charted either regular doses or 'as required.' Staff have received training in medication management and pain management as part of their annual scheduled training programme.
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.	PA Low	Residents' nutritional requirements are assessed on admission to the service in consultation with the residents and family/whānau. The nutritional assessments identify residents' personal food preferences, allergies, intolerances, any special diets, cultural preferences, and modified texture requirements. The cook (interviewed) was aware of resident likes, dislikes, allergies and special dietary requirements. Cultural, religious and food allergies are accommodated. Copies of individual dietary preferences were available in the kitchen folder. A food control plan is in place and expires on 30 September 2025; however, food in the fridge was not always labelled and dated. Nutritional snacks are available for residents 24 hours.
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	FA	Planned discharges or transfers were coordinated in collaboration with the resident and family/whānau to ensure continuity of care. Documented policies and procedures are in place to ensure discharge or transfer of residents are undertaken in a timely and safe manner. The residents and their family/whānau were involved for all discharges to and from the service. Records sampled evidenced that the transfer and discharge planning

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.		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.
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	There is a current building warrant of fitness that expires 22 June 2025. The maintenance person works two days a week and oversees maintenance of the site, gardens and contractor management. Essential contractors such as plumbers and electricians are available 24 hours a day as required. Maintenance requests are logged onto maintenance register in the nurses' office and followed up in a timely manner. An annual maintenance plan includes electrical compliance testing and tagging, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 4.1.1 has been satisfied. Testing and tagging of electrical equipment is next due July 2025. Checking and calibration of medical equipment, hoists and scales is next due in October 2025. Residents are encouraged to bring their own possessions, including those with cultural or spiritual significance, into the facility and can personalise their rooms. The physical environment supports the independence of the residents. The corridors are wide and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. There is access to the outdoor areas from the main lounge/recreation area and the corridors. All areas are easily accessible to the residents. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 4.1.2 has been satisfied.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service	PA Moderate	Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Springvale Manor does not have a copy of fire evacuation plan that has been approved by the New Zealand Fire

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.		Service. The previous audit shortfall (HDSS:2021 # 4.2.1) related to the evacuation plan continues. Fire drills are scheduled six monthly, and the last fire drill was in June 2024. The rusted door between the unit and the evacuation area designated in the evacuation plan has been repaired and a lock is in place (with keys accessible to staff) to enable safe evacuation of residents. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 4.2.1 has been satisfied. The service uses cell evacuation from one area to another. The orientation programme and annual education and training program include fire, emergency, and security training. Staff interviewed confirmed their understanding of emergency procedures.
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 control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, and the training and education of staff. Policies and procedures are provided by an external consultant with input from infection control specialists and reviewed by the management team. Infection control is included in the internal audit schedule. Any corrective actions identified have been implemented and signed off as resolved. The infection control programme is reviewed and reported on annually. Infection prevention and control is part of staff orientation and included in the annual training plan. Staff education includes (but is not limited to): standard precautions; isolation procedures; hand washing competencies; and donning and doffing of personal protective equipment (PPE). The clinical nurse lead is the infection control coordinator. The service receives additional support from expertise at Health New Zealand – Te Whatu Ora.
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	PA Low	Infection surveillance is an integral part of the infection programme as described in the infection prevention and control policy. Monthly infection data is collected for all infections based on signs, symptoms, and the definition of the infection. Infections are entered into the paper-based infection register and surveillance of all infections (including organisms) is collated onto a monthly infection summary. Reports include antibiotic use. This data is monitored and analysed for trends, monthly and annually.

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.		Springvale Manor incorporates ethnicity data into surveillance methods and data captured around infections. Infection control surveillance results are discussed at staff meetings. Meeting minutes and data are available for staff. Action plans are completed for any infection rates of concern. Internal infection control audits are completed, with corrective actions for areas of improvement. Springvale Manor receives regular notifications and alerts from Health New Zealand - Te Whatu Ora for any community concerns. There have been two Covid-19 outbreaks (December 2023 and July 2024) since the previous audit in July 2023. These were not well documented or reported to Public Health as per policy.
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.	FA	Maintaining a restraint-free environment is the aim of the service. Policies and procedures meet the requirements of the standards. An interview with the restraint coordinator (clinical nurse lead) described Springvale Manor's commitment to restraint minimisation. This is supported by the governing body and policies and procedures. On the days of audit there was two residents using bedrail restraints. All documentation including assessments, monitoring and reviews were in place for the records reviewed. However, the care plan did not have detailed interventions (link 3.2.3). When restraint is used, this is a last resort when all alternatives have been explored. The designated restraint coordinator is responsible for the coordination of the approval of the use of restraints and the restraint processes. Review of the restraint assessment confirmed that a holistic assessment is completed prior to use of restraint. This is an improvement from last audit, and the partial attainment related to HDSS:2021 # 6.1.5 has been met. Training for all staff occurs at orientation and annually as sighted in the training records. Staff have been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques. Restraint competencies are completed on orientation and annually for all staff. At all times when restraint is considered, the facility will work in partnership with Māori, to promote and ensure services are mana enhancing.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.7.1 I shall have the right to make an informed choice and give informed consent.	PA Low	There are policies documented around informed consent. Five resident files were reviewed during the audit. One dementia level care resident file did not have a signed general consent. Two resident files did not have signed admission agreements on file.	(i)There were no signed admission agreements in two (one rest home and one dementia) of five files reviewed. (ii)There was no signed general consent form in one rest home level care resident’s file.	(i)-(ii)Ensure that there are signed admission agreements and consent forms on file. 90 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	A complaints register is maintained which includes all complaints and dates; however, for the one internal complaint (dated July 2024) that was logged since last audit, there was no evidence of supporting documents including (but not limited to) complaint acknowledgement letters, investigations, meetings and outcome letters.	There were no supporting documents sighted (including, [but not limited to] complaint acknowledgement letters, investigations, meetings and outcome letters) for the one internal complaint that has been received since last audit	Ensure that complaints process is followed in accordance with guidelines set by the Health and Disability Commissioner. 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	Resident, family/whānau satisfaction surveys are completed annually. The December 2023 resident, family/whānau satisfaction surveys have not been collated and analysed to confirm the level of satisfaction. The results have not been shared with staff, residents and family/ whānau. Three monthly resident, family/ whānau meetings have been completed and provide an opportunity to provide feedback on service delivery as sighted in the minutes reviewed.	(i)Satisfaction surveys for residents, family/whānau were completed in December 2023; however, the results have not been collated analysed and opportunities for continuous improvement identified. (ii)There is no evidence of results of satisfaction surveys shared with staff, residents and family/whanau.	(i)Ensure that there is collation and analysis of satisfaction results. (ii)Ensure that satisfaction results are shared with staff, residents and family/whanau. 90 days
Criterion 2.3.3 Service providers shall implement systems to determine and develop the competencies of health care and support workers to meet the needs of people equitably.	PA Low	Competencies and questionnaires are completed by staff, which are linked to the education and training programme. The clinical nurse lead completed competencies related to medication, controlled drugs, fire safety, documentation, pain, health and safety, infection control, wound, manual handling, restraint, continence and hydration during their orientation and induction period between April and May 2023. These are repeatedly annually however there is no evidence to demonstrate that these have been completed for 2024.	There are no current annual competencies completed by the clinical nurse lead (registered nurse). All the competencies sighted were last completed at the time of orientation in April-May 2023.	Ensure that annual competencies are completed. 90 days
Criterion 3.2.1 Service providers shall engage	PA Moderate	Five resident files were reviewed as part of the audit. Timeframes for assessments, including, but not limited	(i). There was no initial care plan, GP admission, interRAI assessment and long-term care	(i)-(ii). Ensure timeframes for assessments, care plans and GP reviews are met in line

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.		to admission assessments, GP admissions, InterRAI assessments, GP reviews, and care plans were not completed within the contractual timeframes. There is no documented evidence in all five files of resident or family/whānau input into assessment and care planning. The registered nurse is responsible for all residents' assessments, care planning and evaluation of care.	plan for rest home resident who has been at the facility since 6 September 2024. There were no GP admission notes for another dementia resident. (ii). GP monthly or 3/12 reviews have not been completed as scheduled in accordance with ARRC agreement D16.5Eii1 for four resident's files reviewed; three dementia and one rest home level care residents. (iii). Five of five files have no documented evidence of resident or family/whānau input into assessment and care planning.	with the ARRC agreement. (iii). Ensure there is evidence of resident or family/whānau input into assessment and care planning. 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	PA Moderate	The registered nurse completes the cultural assessments but has not completed their current cultural competency, and is reviewing other staff for their cultural safety. The service contracts a GP practice to provide medical treatment for the residents in accordance with ARRC agreement D16.5E. This includes weekly visits for face-to-face reviews of residents for acute concerns, admissions, monthly and three-monthly reviews. However, since July 2024, the service has had a registered nurse prescriber provide medical treatment in lieu of a general practitioner or nurse practitioner. Clinic notes were either documented in the resident's medi-map notes or GP	(i). Cultural assessments are not completed by a culturally competent person (ii). Residents' primary medical treatment is being completed by a nurse prescriber and not a general practitioner or nurse practitioner as per ARRC agreement D16.5E. (iii). There are no detailed interventions in the care plans for four residents (three dementia and one rest home level care resident) to provide guidance to care staff in care delivery in relation to:	(i). Ensure cultural assessments are completed by a culturally competent person. (ii). Ensure resident primary medical treatment is completed by the general practitioner or nurse practitioner as per ARRC agreement D16.5E. (iii). Ensure that long term care plans have detailed interventions to provide care staff with guidance in the delivery of care. (iv). Ensure behaviour

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.		practice electronic system. These were printed and filed in the resident records. The registered nurse is responsible for the development of the care plan. Behaviour assessments were not completed for all dementia level care resident files reviewed. The three files of dementia level care residents also demonstrated that there were no documented interventions of close to normal routine for the residents over a 24-hour period to assist caregivers in the management of behaviours. Assessed risks, alerts and identified interRAI CAPs did not aways have detailed interventions in the care plans to guide staff in the delivery of care. This included those related to diabetes management, falls, communication, mood and behaviour, and restraint. Interview with care staff demonstrated their awareness of resident needs and delivery of care to meet these. Families interviewed were complimentary of the care provided and felt that their loved ones were well looked after.	-management of diabetes management for two rest home residents including reportable ranges, monitoring requirements, signs and symptoms of hypo and hyperglycaemia and management thereof. -falls prevention and management and communication as per interRAI CAP trigger and prevention and management of urinary tract infections for one dementia level care resident. -restraint use, identified risk, their management and monitoring requirements for a dementia level care resident on restraint. -one dementia resident at risk of falls and with mood and behaviour triggered as a CAP with the interRAI assessment. (iv). Behaviour assessments have not been completed for three of three dementia level care resident files reviewed. (v). Three of three care plans reviewed for dementia residents did not include a 24-hour reflection of close to normal routine for the resident with detailed interventions to assist caregivers with strategies for distraction, de-escalation, and management of challenging	assessments are completed for dementia level care residents. (v). Ensure that care plans for residents in the dementia unit provide a 24-hour reflection of close to normal routine for the resident with detailed interventions to assist care staff with strategies for distraction, de-escalation, and management of challenging resident behaviours. 60 days

			resident behaviours.	
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	The service aims to ensure that the provision of services is consistent with and contributes to meeting the resident's assessed needs on an ongoing basis with documentation to evidence this is occurring. However, review of the records confirms that there have not been any registered notes documented in five of the five files. For four of the files the last documented registered nurse entries were in August 2024. The other file was for a resident admitted in September 2024 who did not have admission and ongoing registered nurse progress notes. There were no admission progress notes completed by the registered nurse in three of the files. Short term care plans are developed for short term needs such as infections, wounds, bruises, however these have not always been completed for identified short term needs related to infection for a dementia level care resident in October 2024.	(i). There are no registered nurse progress notes in five of five reviewed. (ii). There are no admission progress notes completed by the registered nurse for three of five resident files. (iii). There was no short-term care plan commenced for chest infection for one dementia level care resident.	(i)-(ii). Ensure there are admission and at least weekly progress notes completed by the registered nurse for each resident. (iii). Ensure short term care plans are completed for short term needs. 60 days
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the	PA Moderate	Medications are stored safely in a locked room. Review of the medications stored in the cupboard confirmed that there were medications not labelled with	(i). Weekly controlled drug checks have not been completed since September 2024. Prior to September 2024 they had not	(i). Ensure weekly controlled drugs checks are completed. (ii). Ensure storage of medications is in line with

service.		resident details in stock. Expired medications, and those for deceased/discharged residents are not always returned to pharmacy in a timely manner. This included controlled drugs for a resident who deceased in September 2024 still in the controlled drug safe. Controlled drugs are stored in a secure safe in a locked cupboard. Review of the controlled drug register showed evidence that weekly controlled drug stock take was last completed on 23 September 2024. Prior to this date the records indicate that weekly stock take of the controlled drugs has not been consistently completed by medication competent staff with some four-week months having two stock takes completed only. Signing charts on the electronic medication system include two signatures for all controlled drugs administered.	been consistently completed weekly. (ii). There are medications in stock for deceased / discharged residents (including controlled drugs), medications not labelled with resident details, and expired medications.	standards and guidelines. 60 days
Criterion 3.4.2 The following aspects of the system shall be performed and communicated to people by registered health professionals operating within their role and scope of practice: prescribing, dispensing, reconciliation, and review.	PA Moderate	Controlled drugs are delivered mostly in the afternoon by the pharmacist and signed in by medication competent caregivers. There is no evidence of registered nurse oversight and reconciliation of controlled drug stock in the records reviewed.	Controlled drugs are delivered and signed in by the medication competent caregivers. The registered nurse is currently providing no oversight by way of weekly checks; therefore, the service is not meeting safe reconciliation processes.	Ensure registered nurse oversight with controlled drugs reconciliation processes. 60 days

Criterion 3.5.5 An approved food control plan shall be available as required.	PA Low	There is an implemented and verified food control plan in place which expires 30 September 2025; however, review of decanted and stored food in the fridge confirmed that the containers did not have labels and were not dated on opening or decanting. This included food such as asparagus in a lunch box, salad, jam and decanted sauces.	Food stored in the fridge was not always labelled and dated.	Ensure food is labelled and dated. 90 days
Criterion 4.2.1 Where required by legislation, there shall be a Fire and Emergency New Zealand-approved evacuation plan.	PA Moderate	Springvale Manor does not have a copy of a Fire and Emergency New Zealand (FENZ) approved fire evacuation plan. Since the last audit the organisation has since changed the fire security services provider. At the time of the audit, documented evidence reviewed confirmed that the required repairs were completed and request for sign off of the evacuation scheme submitted to FENZ. Email response from FENZ dated 3 October 2024 (sighted) advises that the request is awaiting sign off decision scheduled in November 2024.	There is no Fire and Emergency New Zealand (FENZ) approved fire evacuation plan in place	Ensure that there is an approved fire evacuation plan in place for the service. 60 days
Criterion 5.4.1 Surveillance activities shall be appropriate for the service provider and take into account the following: (a) Size and complexity of the service; (b) Type of services provided; (c) Acuity, risk factors, and	PA Low	Springvale Manor receives regular notifications and alerts from Health New Zealand - Te Whatu Ora for any community concerns. There have been two Covid-19 outbreaks (December 2023 and July 2024) since the previous audit in July 2023. There were no outbreak logs, meetings conducted, evidence of registration of the infections into the Ministry of Health portal or	Outbreak management processes have not been complied with for the two Covid 19 related outbreaks that have occurred since last audit.	Ensure that outbreak management processes are implemented as per policy and guidelines. 90 days

needs of the people receiving services; (d) Health and safety risk to, and of, the workforce; (e) Systemic risk to the health and disability system as a whole.		notification to public health. There were no short-term care plans developed for the residents affected by the infection. The infections were recorded on the monthly surveillance report and the meeting minutes.		

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.

No data to display

End of the report.