

Athenree Life Limited - Athenree Lifecare

Introduction

This report records the results of a Provisional Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

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

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

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

The specifics of this audit included:

Legal entity:	Athenree Life Limited
Premises audited:	Athenree Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 12 October 2020 End date: 13 October 2020
Proposed changes to current services (if any):	Change of ownership.
Total beds occupied across all premises included in the audit on the first day of the audit:	41

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 outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

General overview of the audit

Athenree Rest Home and Hospital provides rest home, dementia and hospital level care for up to 43 residents. The facility is operated by Athenree Lifecare Limited. The service is managed by an acting facility manager/clinical nurse manager. Residents and families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, the owners and a general practitioner.

The audit also established how well prepared the prospective provider is to provide a health and disability service. The director for Athenree Life Limited was interviewed during this audit. The prospective provider understands the Health and Disability Standards and the Age Residential Related Care Agreement.

Improvements required from this audit relate to privacy for residents occupying the double room; the internal audit programme; meeting minutes; a quality review of restraint use; analysis of data and corrective actions; reporting quality data back to staff; a health and safety representative; the education programme; rostering; general practitioner visits; individualisation of care plans; monitoring of hot water temperatures; the call bell system and the infection control programme.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Athenree Lifecare. Opportunities to discuss the Code, consents and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided in a manner that respects the choices, independence, individual needs, and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreting services if and when required. Staff provided residents and families with the information they need to make an informed choice and to give consent.

The owners are responsible for the management of complaints and a complaints register is current. There have been no investigations by external agencies since the previous audit.

Organisational management

Athenree Lifecare Limited is the governing body and is responsible for the service provided. A business and quality and risk management plans include a mission statement, philosophy scope, objectives, values, and goals. The owners are on site each day and have close contact with the acting facility manager/clinical nurse manager.

The service is managed by an experienced clinical nurse manager who is also currently managing the facility in an acting capacity. The manager is supported by the owners and senior registered nurses.

There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms are completed, and quality data evidenced some analysis and corrective action plans being developed, implemented, monitored and signed off as being completed to address the issue/s that required improvement. Various meetings are held.

The hazard register evidenced review and updating of risks and the addition of new risks.

Policies and procedures on human resources management are in place and processes are followed. In-service education has been provided and staff performance is monitored.

A documented rationale for determining staffing levels and skill mixes is in place. Registered nurses are always rostered on duty. The acting facility manager and the owners are on call after hours.

Residents' information was accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records were maintained using an electronic and hard copy files.

Continuum of service delivery

Athenree Lifecare works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans implemented for each resident are based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and family members of residents, when interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and an activities coordinator. The programmes provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by either registered nurses, an enrolled nurse or care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents and family members of residents verified overall satisfaction with meals.

Safe and appropriate environment

A current building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

Apart from one double room, single accommodation is provided with a mix of full ensuites and rooms with a wash hand basin. Adequate numbers of additional bathrooms and toilets are available. There are lounges, dining areas and alcoves. External areas for sitting and shading are provided.

Security and systems are in place. Residents and families reported timely responses to call bells.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is undertaken on site and both cleaning and laundry is evaluated for effectiveness.

Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held six monthly.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Restraints were in use. Documentation included assessment, approval, monitoring and individual evaluation processes. Staff interviewed demonstrated knowledge and understanding of restraint minimisation and safe practice.

Infection prevention and control

The infection prevention and control management at Athenree Lifecare, is overseen by an experienced and appropriately trained infection control nurse and aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the Bay of Plenty District Health Board.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies.

Aged care specific infection surveillance is undertaken, and data is analysed and trended. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards 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)
Standards	0	41	0	2	7	0	0
Criteria	0	89	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Athenree Lifecare (Athenree) has policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed at Athenree understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information.</p> <p>Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to</p>

		<p>consent is defined and documented where relevant in the residents' files. Staff demonstrated their understanding by being able to explain situations when this may occur. Two of three residents' files reviewed in the secure unit had an enduring power of attorney (EPOA) in place and activated. The third file had evidence of a recent application (May 2020) to the court for the protection of the resident's personal property.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents/family members are given a copy of the Code, which also includes information on the Advocacy Service. A poster related to the Advocacy Service was also displayed at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The owners are responsible for the management of complaints. The complaints and compliments forms and associated documents meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and was</p>

		<p>available throughout the facility. Residents and families knew how to make a complaint and to provide compliments.</p> <p>The complaints register evidenced two complaints have been received since the previous audit and that actions taken through to an agreed resolution were documented and processes completed within the timeframes required. Action plans showed any required actions or improvements that have been made where possible. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaint investigations by external agencies since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family members of residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</p> <p>The prospective provider demonstrated knowledge and understanding of consumer rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>PA Moderate</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, when exchanging verbal information and during discussions with families and the GP. All but two residents residing in Athenree have a private room. This room does not enable the residents' privacy during cares to be maintained, and this requires attention.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops</p>

		<p>or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff and except for this year, is provided on an annual basis (refer criterion 1.2.7.5).</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are two residents in Athenree at the time of audit who identify as Māori. Interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers from the Bay of Plenty District Health Board (BOPDHB).</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and residents' family members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Residents' personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A 2019 resident satisfaction questionnaire included evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and residents' family members interviewed, stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed</p>

		<p>satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff at Athenree includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Except for this year (refer criterion 1.2.7.5), ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Athenree encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, psychiatrists, psychogeriatricians and mental health services for older persons. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support to access education and access professional networks, such as training sessions at the BOPDHB, and online webinars. Over 50% of healthcare assistants (HCAs) at Athenree have level four qualifications in caring for the older adult, with all but two HCAs having level two or level three qualifications. On-line forums are regularly used as an education tool, to support contemporary good practice.</p> <p>Examples of good practice observed during the audit included a commitment to minimising pressure injuries, with no residents having pressure injuries; installation of surveillance cameras in public areas in the secure unit, to enable the circumstances leading to falls to be better monitored; an individualised approach to resident care and familiarity with knowing the resident and their families; and the ongoing cooperative and supportive relationship between older persons mental health services at the BOPDHB and Athenree.</p>

		<p>Family members interviewed described the care provided at Athenree as 'magnificent'. The environment is attractive, warm, and friendly. The décor portrays a homely environment, with minimal medical connotations. Residents in the secure unit were observed to move around freely. Any situations of potential conflict were quickly de-escalated by staff in a calm and respectful manner. Doors in the unit are colour coded for easy identification by the resident. Exit doors are disguised by murals, and residents were observed not to be waiting to leave.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the BOPDHB. Staff knew how to do this, though reported interpreter services were rarely required at Athenree.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Athenree Lifecare Limited is responsible for the services provided. A business plan 2019-2020 was reviewed and included a mission statement, philosophy, specific goals and objectives. The business plan is reviewed annually by the owners.</p> <p>The acting facility manager/clinical nurse manager (AFM/CNM) has been in the position of AFM since January 2020 following the resignation of the previous manager. The owners have experience in management and stated they took responsibility for some of the non-clinical activities and stated the plan was to have support from the facility manager of their other facility nearby. Lockdown during Covid-19 interrupted this arrangement. The owners reported that following lockdown they advertised for a new facility manager and interviewed</p>

	<p>two candidates; however, once the candidates were informed that the current owners were selling the facility, both candidates decided to withdraw their applications.</p> <p>The AFM/CNM is an experienced RN and has been in their current position of CNM for 15 months and prior to the appointment was an RN on the floor. There was evidence in the AFM/CNM file of appropriate ongoing education and a current practising certificate.</p> <p>The current owners advised HealthCERT of the change of facility manager during the onsite audit.</p> <p>The prospective provider, Athenree Life Limited, consists of one owner. The prospective provider, who is an RN, is experienced in the aged care sector and currently owns two other aged care facilities. The prospective provider plans to be the facility manager for this facility.</p> <p>A comprehensive transition plan reviewed and interview of the prospective provider and the current owners evidenced the current owners are committed to providing a comprehensive handover during the transition period until January 2021 when the prospective provider reported they will take ownership. The prospective provider's business plan and quality and risk plan was also reviewed.</p> <p>The prospective provider stated all staff will be offered new contracts. The prospective provider will provide support to the domestic and clinical team. The current owners reported they have notified the District Health Board prior to the provisional audit being undertaken. The prospective provider reported they plan to liaise with the District Health Board following the audit.</p> <p>Occupancy on the first day of the audit was 41 residents. Fourteen residents were assessed as being at hospital level, 15 at rest home level and 12 dementia. One hospital level and two rest home level residents were under the long-term support - chronic health conditions contract and one dementia level resident was under the respite contract. The remaining residents were under the aged related residential care contract.</p> <p>The owners reported 29 of the rooms in the rest home/hospital areas</p>
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		have been approved as dual-purpose rooms.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the AFM/CNM is absent a senior RN covers the clinical aspects of the service with support from the FM who manages the sister facility nearby. During absence of the clinical manager a senior registered nurse is available to cover for the clinical manager. The current owners stated they take responsibility for all non-clinical matters.</p> <p>The prospective provider understood the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Moderate	<p>The quality, risk management plan guides the quality programme and includes a mission, goals and objectives. An internal audit programme is in place and non-clinical audits were completed; however, no clinical audits have been completed for 2020. A quality review of restraint has not been undertaken.</p> <p>There was some evidence of various meetings being held during 2019 and 2020. There were gaps in the minutes reviewed, apart from the lockdown period during Covid-19 when memos and texts were provided to staff. Meeting minutes did evidence reporting of completed internal audits; however, quality data, including clinical indicators which are graphed, were not reported back to staff.</p> <p>There was documented evidence that quality improvement data is being collected and collated. Analysis of quality data and identification of trends is rudimentary and not reported back to staff. Quality improvement data included adverse event forms, internal audits, meeting minutes, satisfaction surveys, infection rates and health and safety. Corrective action plans are inconsistently completed or not completed following deficits identified including audits, meeting minutes and the resident satisfaction survey for 2019.</p> <p>Relevant standards are identified and included in the policies and</p>

		<p>procedures manuals. Policies and procedures reviewed were relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. The AFM/CNM stated the organisation is currently changing from one system to another. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly. Staff confirmed they were advised of updated policies and that they provided appropriate guidance for service delivery. Obsolete documentation is shredded.</p> <p>Health and safety policies are available. Actual and potential risks are identified associated with all activities at the facility. The hazard register identifies hazards and evidenced the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. There is currently no health and safety representative at the facility. Staff confirmed they understood and implemented documented hazard identification processes.</p> <p>The prospective provider advised the policies and procedures currently being implemented will continue to be implemented and the quality and risk management plan will remain the same and be reviewed in three months following ownership.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form including neurological observation and falls risk assessments following accidents/incidents as appropriate. The RNs are responsible for reviewing the forms before they are reviewed and collated by the AFM/CNM. A copy is kept in the resident's file. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. The satisfaction survey confirmed this.</p> <p>Staff stated they are made aware of their essential notification</p>

		<p>responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The owners advised there have been four essential notification made to the Ministry of Health since the previous audit. Documentation reviewed confirmed this.</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective provider is aware of all current health and safety legislative requirements and the need to comply with these.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Policies and procedures relating to human resources management are in place. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments for medication management, education records and police vetting.</p> <p>An education programme for 2020 was not available and although some inservice sessions have been provided, ongoing education has not been consistent. A programme for 2019 was sighted; however, the programme was not followed. Staff undertake some on-line learning and stated they talk at handover about specific topics. Registered nurses attend ongoing education provided by the DHB. Individual records of education are held on staff files and electronically. Competencies were current for medicine administration; however, competencies for restraint were not current. The six RNs are interRAI trained and have current competencies, plus the AFM/CNM.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. The EN is the assessor for the facility. Twelve HCAs have completed level 4, two have attained level three and two have attained level two.</p> <p>An orientation/induction programme is in place and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of</p>

		<p>competencies, takes up to a month to complete and staff performance is reviewed at 12 weeks and annually thereafter. Orientation for staff covers all essential components of the service provided.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff stated on-going training is not consistently provided. Staff also confirmed the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Low</p>	<p>There is a documented rationale for determining staffing levels and skill mixes. The rosters are the responsibility of the owners and they reported they review the rosters continuously and consider dependency levels of residents and the physical environment. The RNs work 12-hour shifts. There is one RN and five HCAs rostered on the morning shift, plus the AFM/CNM who works full time Monday to Friday inclusive. One RN and five HCAs are rostered on the afternoon shift and the afternoon/night RN and two caregivers are on the night shift. Domestic staff are responsible for managing the laundry and cleaning. There is a diversional therapist and activities person and both work across all services. The AFM/CNM and owners are on-call after hours.</p> <p>Review of the rosters and interviews of care staff, residents and families evidenced the morning shift does not have enough HCA hours provided in the rest home/hospital wings. Review of the rosters evidenced a third HCA was rostered on in the rest home/hospital wings in June and July 2020.</p> <p>The prospective provider reported they intend to increase the HCAs hours on the morning shift. The prospective provider understood the required skill mix to ensure hospital, rest home and dementia residents needs are met.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents are admitted when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service, as requiring the services provided by Athenree. Prospective residents and/or their families are encouraged to visit the facility prior to admission. They are also provided with written information about the service and the admission process.</p> <p>All residents in the secure unit have activated EPOAs in place or applications for PPPR (refer 1.3.10). Specialists notes authorising placements in the secure unit are sighted in files reviewed.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit,</p>	<p>FA</p>	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the InterRAI transfer form to facilitate transfer of residents to and from acute care</p>

<p>discharge, or transfer from services.</p>		<p>services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p>

		<p>There were no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner if required.</p> <p>Medication errors are reported to the RN and CNM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Athenree.</p> <p>There was minimal use of antipsychotics and pro-re-nata (PRN) (as required) medication in the unit, as evidenced in a review of medication records.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian - 5 October 2020. Recommendations made at that time have been implemented. A new cook has just commenced at Athenree on 16 September 2020. Evidence verified the cook is qualified for the role.</p> <p>An up to date food control plan certificate is onsite and expires May 2021. An onsite verification audit of the plan was not undertaken, it was completed via a Zoom meeting, due to Covid-19 restrictions.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences (eg, increased salt), any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet</p>

		<p>residents' nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by residents and residents' family members interviewed, satisfaction surveys and residents' meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed.</p> <p>Residents in the secure unit have access to food anytime night or day.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received by Athenree, but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents of Athenree are initially assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessments using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are</p>

		<p>completed within three weeks of admission and at least every six months unless the resident's condition changes. Interviews, documentation, and observation verified the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by the trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Plans reviewed reflected the generalised support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Residents in the secure unit had behaviour management plans in place that included behaviour management plans , including triggers and interventions for behaviours.</p> <p>Care plans did not always evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was not always documented though interviews verified this was verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Except for that referred to in 1.3.5.2, documentation, observations and interviews verified the provision of care to residents of Athenree was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A</p>

		range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme at Athenree is provided by a trained diversional therapist and an activities coordinator. A dedicated activities person is in the secure unit five days a week, and there is a dedicated activities programme for this unit. This addresses a previous corrective action request that required a resident trained in activities to oversee the programme and dedicated activity hours to be provided in the unit.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated regularly and as part of the formal care plan review every six months care plan.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. The dementia unit's activities plan includes, local walks, exercises, dance, crafts, games, balloon tennis, happy hour, picture bingo, entertainment, and van outings. The programme in the hospital/rest home includes similar activities however they are a bit noisier. Visiting entertainers in the main lounge often include resident from the secure unit. Van outings for everyone and one just for the unit residents, occur weekly.</p> <p>The activities programme is discussed at the residents' meetings and minutes indicated residents' input is sought and responded to. Resident meetings have been held every three months. A family meeting was held on the 7th October 2020 to keep families up to date with the proposed sale, Covid-19, a new cook, activities and cleaning practices. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents and residents' family members</p>

		interviewed confirmed they find the activities programme meets the needs of residents.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	FA	<p>Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely</p>

<p>harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>manner. Safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current.</p> <p>Protective clothing and equipment were sighted in the sluice rooms and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>A current building warrant of fitness is displayed at the front entrance. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for purpose. Passageways are wide and residents confirmed they can move freely around the facility and that the accommodation meets their needs.</p> <p>There is a proactive and reactive maintenance programme, and the buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by one of the owners and was observed to be of a high standard. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. Hot water temperatures have not been consistently monitored.</p> <p>External areas are available and are maintained to an adequate standard and are appropriate to the resident groups and setting. The outside area for residents in the dementia unit is secure. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. The gardens are maintained including a courtyard in the centre of the facility and some residents' bedrooms face the courtyard.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p> <p>The prospective provider stated there are currently no plans for any environmental changes to the facility.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Three rooms have their own ensuite and the rest have a wash hand basin. There are additional toilets and showers in close proximity to the residents' rooms. All bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. Separate bathrooms for staff and visitors are available.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. Apart from one double bedroom (refer criterion 1.1.3.1), all other bedrooms provide single accommodation. Rooms are personalised with furnishings, photographs and other personal items on display. Bedrooms are large enough for residents and staff with equipment to manoeuvre within.</p> <p>There is adequate room in the facility to store mobility aids such as mobility scooters, wheelchairs and walkers.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to frequent. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy. There is one smaller lounge available for this purpose. The furniture in the lounges and dining rooms is appropriate to the setting and residents' needs.</p> <p>There is adequate space to accommodate wheelchairs in the dining room and a large lounge if required.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is washed and dried on site. The laundry has clean and dirty flows. Cleaners and laundry staff demonstrated a sound knowledge of the laundry processes, dirty and clean flow and handling of any soiled linen. Residents and families interviewed reported the personal clothes are mostly managed effectively and returned in a timely manner. There are separate named baskets for</p>

		<p>each individual resident.</p> <p>The facility is cleaned to an adequate standard. The cleaners have received appropriate training. The cleaners have completed training from the chemical company representative who visits monthly. Chemicals are stored in a lockable cupboard and were in appropriately labelled refillable containers. The cleaning trolley is stored in a locked room when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 25 September 2006. A fire evacuation drill takes place six monthly with a copy sent to the New Zealand Fire Service. The orientation programme includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Policies and procedures and guidelines for all emergency planning, preparation and response are displayed and flip charts are also displayed throughout the facility to guide staff. Disaster and civil defence planning guides direct the facility in their preparedness for disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>Adequate supplies for use in the event of a civil defence emergency including food, water, blankets, torches, mobile phones and a gas barbecue were sighted and meet the requirements for the number of residents able to be accommodated at the facility. Water storage meets the requirements for the emergency water storage recommendations for the region. External emergency lighting is battery powered. These resources are regularly tested and recordings were validated.</p> <p>There are two different types of call bell systems throughout the facility and they are not connected. One system has no emergency call bell and is not connected to a mimic board so that staff have to physically seek help from the other wing. There is no call bell in the main lounge or dining room in the rest home/hospital area.</p> <p>Appropriate security arrangements are in place. Doors and windows</p>

		are locked at a predetermined time and the facility is checked by staff. Surveillance cameras were evident in the communal areas of the dementia facility and signage is displayed.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	Heating is provided by electric wall heater and heat pumps. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. There is a covered external area for smokers.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	PA Low	<p>The service provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the presence of infection prevention and control (IPC) policies to guide practice. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from an external advisory company, the FM at a sister site and the infection control nurse (ICN) at BOPDHB.</p> <p>There is no documented infection control programme that identifies objectives of the programme, how these will be achieved and how the effectiveness of the programme will be evaluated. The infection control programme has not been reviewed annually. This requires attention.</p> <p>The RN, with input from the CNM, the FM of the sister site and the ICN from BOPDHB is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CNM. Infection control statistics are entered in the organisation's infection log. The organisation's owner is informed of any IPC concerns.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long</p>

		they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control nurse coordinator at Athenree has been in the role since January 2020 and has no qualifications for the role, however, is supported by the CNM, the FM from the sister site and the ICN from the DHB. Well-established local networks with the infection control team at the BOPDHB are available and expert advice from public health is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC and CNM confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last two years and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control training annual plan. This however has not been adhered to this year (refer criterion 1.2.7.5). Interviews, observation and documentation verified staff have received some education in IPC at orientation and ongoing ad hoc education sessions. Education is provided by the CNM or the infection control nurse coordinator after gaining advice from the sister site FM (trained in IC through an external IC advisor)</p>

		<p>or the ICN at BOPDHB. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, quarantine, Covid-19, restrictions on leaving the facility, limitations on visitors, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control nurse coordinator and CNM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at staff handovers. Surveillance data is entered in the organisation's infection database.</p> <p>A Norovirus outbreak occurred at Athenree in March 2020 and involved all residents in the secure unit, plus six residents in the hospital rest home. Several staff were affected and the outbreak lasted two weeks. Public health and the BOPDHB were informed.</p> <p>A good supply of personal protective equipment is available. Athenree has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	FA	<p>The service demonstrated that the use of restraint is actively minimised. There were four residents using restraint and no residents</p>

<p>minimised.</p>		<p>using an enabler during the audit. Enablers were the least restrictive and used voluntarily at the residents' requests. The restraint coordinator is the AFM/CNM and demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register was current and updated. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>Restraint approval is authorised by the AFM/CNM, the GP and family. It was evident from review of restraint approval forms and residents' records and interviews with staff and AFM/CNM that there are clear lines of accountability that all restraints have been approved and the overall use of restraints is being monitored and analysed. Evidence of family involvement in the decision making was on record in each case.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were clearly documented and included all requirements of the standard. Assessments including a risk questionnaire is completed by the AFM/CNM or an RN with involvement and input from the resident's family. The AFM/CNM described the documented process. The GP is involved in the final decision on the safety of the use of the restraint. The assessment process using a restraint/enabler questionnaire identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks involved. Completed assessments were sighted in the records of residents who were using a restraint. Residents and families are given an information sheet relating to restraints and the risks associated with the use.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraint is actively minimised and the AFM/CNM described alternatives to restraints including low low beds, sensor mats and landing pads. When restraints are in use, frequent monitoring occurs to ensure the resident is safe. Records of monitoring had the necessary details and were completed correctly.</p>

		<p>Access to advocacy is provided and all processes ensure dignity and privacy are maintained and respected by staff and others.</p> <p>A restraint register is maintained and updated regularly. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>There was no evidence to indicate that staff have received restraint education during 2019 and 2020 and restraint competences are not current (Refer to criterion 1.2.7.5).</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' records evidenced the individual use of restraint is reviewed and evaluated along with the six-monthly care plan evaluations, interRAI reviews and GP reviews. Families confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraint use is reviewed six monthly in line with the review of residents' care plans. Restraint use is reported by the restraint coordinator at the RN and staff meetings. There was one restraint meeting held in March 2020 (refer to criterion 1.2.3.1). A quality review of restraint has not been completed (Refer to criterion 1.2.3.1).</p>

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	<p>PA</p> <p>Moderate</p>	<p>Staff at Athenree understood the need to maintain privacy and were observed doing so throughout the audit, however when providing care to two residents sharing a room, staff acknowledged one resident's privacy could not be maintained. The bedroom concerned is shared by two residents. Consent to share the bedroom has been obtained. Both residents require full cares to be provided in the room. The curtaining in the room is insufficient to maintain the privacy of both residents when cares are being attended to.</p>	<p>There is one large bedroom that is shared by two residents. The shared room does not enable each resident's privacy to be maintained.</p>	<p>Provide evidence of changes made to maintain the privacy for the residents who are sharing a room.</p> <p>30 days</p>
<p>Criterion 1.2.3.1</p> <p>The organisation has a</p>	<p>PA</p> <p>Moderate</p>	<p>A quality, risk management plan is in place; however, there are gaps</p>	<p>The internal audit programme does not show when the clinical</p>	<p>Provide evidence that: (i) the audit programme is updated,</p>

<p>quality and risk management system which is understood and implemented by service providers.</p>		<p>relating to the implementation of the plan. An internal audit programme for 2020 evidenced four non-clinical audits were completed for 2020 and not all audits for 2019 were completed. The programme does not indicate when the clinical audits are to be undertaken and none have been completed for 2020 to date. A quality review of restraint use has not been completed.</p> <p>Meetings held during 2019 and 2020 were not consistently held. Review of minutes and interviews of staff evidenced gaps in meetings held. During Covid-19 lockdowns memos and texts were provided to staff to keep them up to date. Two infection control meetings were held during 2020 and there was no evidence available to indicate any meetings had been held in 2019. One restraint meeting minutes were sighted from a meeting held in March 2020. Staff confirmed meetings are not held on a regular basis.</p>	<p>audits are scheduled and no clinical audits have been completed to date for 2020. Not all non-clinical audits have been completed. There are gaps when various meetings are held, and no infection control meetings were held in 2019.</p>	<p>and audits are completed as per the programme, including the quality audit of restraint; and (ii) meetings are held on a regular basis.</p> <p>90 days</p>
<p>Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Low</p>	<p>Quality improvement data is collected and collated by the AFM/CNM and monthly graphs are generated. There was evidence of some analysis of data and trending, however this was not comprehensive and consisted mainly of numbers. Meeting minutes evidenced reporting of completed internal audits; however, quality data, including clinical indicators are not</p>	<p>Analysis of clinical indicators and identifying any trends is not comprehensive and minutes of meetings evidence a lack of reporting back to staff.</p>	<p>Provide evidence that (i) quality data is comprehensively analysed to identify trends (ii) meetings are held on a regular basis and that meetings include reporting back to staff clinical indicators for each month and discussion relating to this.</p>

		reported back to staff and discussed. Staff interviewed confirmed this. The AFM/CNM reported graphs are made available for staff to read but are not presented at the meetings.		90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>There was some evidence of completed corrective action plans following the completed audits for 2019 and non-clinical audits of 2020; however, evidence showed these were inconsistent. Corrective actions have not been completed for deficits identified in the resident satisfaction survey of 2019 and meeting minutes. There was no evidence that corrective actions have been evaluated to indicate the action has been successful.</p>	<p>Corrective actions are inconsistently developed and implemented when deficits are identified. Evaluation of the corrective actions was not evidenced.</p>	<p>Provide evidence that corrective actions are developed for all deficits identified and evaluated to indicate the corrective action has been successful.</p> <p>90 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the</p>	PA Low	<p>Health and safety policies documentation is in place. Actual and potential risks are identified associated with human resources management, legislative compliance, contractual and clinical risk. The hazard register identifies hazards and evidenced the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. A health and safety representative has not been replaced since the previous person left employment in March 2020. The owners demonstrated</p>	<p>A health and safety representative has not been appointed since the representative left employment in March 2020.</p>	<p>Provide evidence that a health and safety representative has been appointed who has completed appropriate training.</p> <p>90 days</p>

<p>status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>knowledge of health and safety activities and responsibilities relating to the current legislation. Staff confirmed they understood and implemented documented hazard identification processes.</p>		
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>The education programme is the responsibility of the AFM/CNM. A 2020 programme was not available and ongoing education has happened in an adhoc manner. Not all required training has been provided during 2019 and the programme has not been followed. Staff undertake some on-line learning and stated they talk at handover about specific topics relating to resident's health status. Registered nurses attend some ongoing education provided by the DHB. Individual records of education and competencies are held on staff files and electronically, however the spread sheet was last updated in 2017. Medicine administration competencies were current, however competencies for restraint were not. The six RNs and the AFM/CNM are interRAI trained and have current competencies. Care staff in the dementia unit have either completed the dementia specific units or are currently completing this.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. The EN</p>	<p>There is no education programme for 2020 and training has not been consistently provided, including all core subjects during 2019 and 2020. Competencies for restraint are not current.</p>	<p>Provide evidence that an education programme is developed and implemented for 2020 that includes all required subjects, and competencies for restraint are current.</p> <p>60 days</p>

		is the assessor for the facility.		
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>A rationale for determining staffing levels and skill mixes to provide safe service delivery is in place. The owners are responsible for rostering and reported they review the rosters continuously and consider dependency levels of residents and the physical environment. The RNs work 12-hour shifts. One RN and five HCAs are rostered on the morning shift, (three HCAs in the rest home/hospital wings and two in the dementia unit), plus the AFM/CNM who works full time Monday to Friday inclusive. One RN and five HCAs are rostered on the afternoon shift and the afternoon/night RN and two caregivers are on the night shift. There are dedicated staff to manage the laundry and cleaning. The owners are responsible for all maintenance. There is a diversional therapist and activities person and both work across all services. The AFM/CNM is on-call after hours.</p> <p>Care staff interviewed reported they are not able to get through their work on the morning shift and the number of HCAs available is inadequate to provide residents with safe care. Residents and families interviewed stated staff are sometimes rushed on the morning shift. Observations during this audit evidenced a significant number of residents with complex</p>	<p>Review of the current rosters and interviews of care staff, residents and families and observations during the audit evidenced the morning shift does not have adequate HCA hours provided in the rest home/hospital areas.</p>	<p>Provide evidence that HCA hours are increased on the morning shift to provide residents with safe care.</p> <p>90 days</p>

		<p>needs and confirmed HCAs are rushed. Of the RNs employed, one RN was a new graduate employed in January 2020 and prior to the appointment was a HCA. One RN has completed the 'CAP' course and has been employed for a year, the rest of the RNs are experienced in the aged care. The other RNs have more than two years experience.</p> <p>The owners interviewed stated they are aware of the short fall on the morning shift and that a sixth HCA was rostered on, however the new HCAs have not lasted because of the dynamics amongst some of the HCAs. Review of the rosters evidenced a third HCA was rostered on in the rest home/hospital wings in June and July 2020.</p>		
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>Nine residents' files were reviewed. One file of a resident admitted in March 2020, has no documentation verifying they had been seen or reviewed by a GP since admission. The respite resident had not been reviewed and did not require GP services. The remaining seven files had GP documentation on admission, and verification the residents were stable and able to be reviewed every three months, however documentation verifying consistency in visits, reviews and medical instructions was not sighted. An interview with the clinical care</p>	<p>Residents are not consistently assessed by their GP within 2-5 days of admission or reviewed within time frames that are appropriate for their needs.</p>	<p>Provide evidence that residents are seen by the GP within 2-5 days of admission, and reviewed as the residents' condition changes or monthly, unless stable and able to be reviewed every three months.</p> <p>60 days</p>

		<p>manager (CCM), identified the GP visits regularly and there is a schedule when residents need to be seen. The GP writes the notes up off site and sends them up after leaving the facility. Often the GP needs to be reminded to send the consult notes. The CCM and one of the facility shareholders (present at audit) acknowledged that medical notes were not on site to evidence GP visits and GPs requests or orders. The electronic medication review records verified the medications have been reviewed every three months.</p>		
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The care plans of residents at Athenree do not always describe fully the care the resident requires to meet the desired outcome. A resident receiving nutritional support through percutaneous endoscopic gastronomy feeding, had no feeding regime documentation. No details were documented describing the appropriateness and regime of the resident having food orally. A management plan for a resident on continuous oxygen therapy if oxygen levels dropped, was not documented or verified by the GP. A resident on anticoagulant therapy had no plan detailed around frequency of testing to monitor levels and observations required to monitor risk. A resident on restraint has no plan in place identifying the management strategies</p>	<p>Care plans do not always describe the required support required to meet the residents' desired outcomes.</p>	<p>Provide evidence that care plans describe fully the support required for residents to achieve the desired outcomes.</p> <p>90 days</p>

		<p>to monitor the risks associated with restraint and this resident. A resident had a medication dose altered and medical notes requested monitoring for drowsiness and a specialist report requested medication doses to be reduced. No documentation was sighted around this in the care plan.</p> <p>Interviews with staff, residents, residents' families, and observations verified the care required was being provided despite no documentation being in place.</p>		
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>A current building warrant of fitness is displayed that expires 3 December 2020. Testing and tagging of equipment is current as is calibration of bio-medical equipment. Review of documentation evidenced hot water temperature monitoring at resident outlets is inconsistent and some months there has been no monitoring undertaken. Review of the recordings that were available evidenced temperatures were in the required range.</p>	<p>Hot water temperatures are not consistently monitored.</p>	<p>Provide evidence that hot water temperatures at resident outlets are consistently monitored to ensure temperatures remain within the required range.</p> <p>30 days</p>
<p>Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA Moderate</p>	<p>There are two wings in the rest home/hospital area, each with a different call bell system that work independently of each other. One system works well and has an emergency alarm connected to it that alerts staff by sound. This system is</p>	<p>The two call bell systems are not integrated, and one has no emergency call bell and alerts are not connected to a mimic board or the other system. This means there is potential risk for residents and staff in an</p>	<p>Provide evidence that the call bell system throughout the facility provides residents and staff with appropriate means to summons assistance.</p>

		connected to a mimic board in the wing it serves. When a call bell is activated using the second system, the alert does not come up on the mimic board and the sound omitted by the alert is low and difficult to hear. In addition, there is no emergency alert and it is not connected to the other system. This means there is no audible emergency alert if staff require assistance. If one staff member is working in the wing, they have to physically leave the wing to find help. Observations and interviews of care staff confirmed this.	emergency as staff must physically leave the wing to seek help.	90 days
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Low	Athenree has an infection control manual that has a range of policies to guide practice in relation to infection control practices. Evidence verified staff training in handwashing, education on Norovirus, Covid-19 and training in using and removing PPE gear. Staff are familiar with contact precautions and can describe the management strategies when these are required. There is no documented infection control programme that details the strategies in place to evidence a managed environment that minimises the risk of infection to staff residents and their families.	The organisation has no documented infection control programme.	<p>Provide evidence that an infection control programme is in place and will be reviewed yearly.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard 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 standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

No data to display

End of the report.