# New Windsor 2017 Limited - New Windsor Aged Care

## Introduction

This report records the results of a Surveillance 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 HealthShare 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** New Windsor 2017 Limited

**Premises audited:** New Windsor Aged Care

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 24 November 2020 End date: 24 November 2020

**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:** 22

# 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.

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards 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 standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards 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 standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

New Windsor Rest Home provides rest home level care for up to 27 residents, all of whom are of Chinese descent. There were 22 rest home level residents on the day of the audit. The service is owned and operated by the management team, with support from a registered nurse. There have been some changes to the service since the last audit. This includes the appointment of a new registered nurse and a reconfiguration to provide an additional bedroom. Residents and family spoke positively about the care provided.

This surveillance audit was conducted against a sub-set of the Health and Disability Service 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, family management and staff. The general practitioner was not available for interview. All interviews were conducted with an interpreter.

There were eight areas requiring improvement identified at the last audit. There has been some progress towards these with four now considered fully addressed. This audit has resulted in additional areas requiring improvement relating to satisfaction surveys, essential notifications, human resources, evacuation processes, medication and the infection prevention and control surveillance programme.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Open communication between staff, residents and families is promoted. There is access to interpreting services if required and most documents are in a language that is spoken and understood by the residents and relatives. Staff provide residents and families with the information they need to make informed choices and give consent.

The complaints process meets the requirements of consumer rights legislation. A complaints register has been maintained.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The organisation is governed by the owners/managers who are on site daily and monitor organisational performance. There is a documented quality and risk management system. Quality activities are defined. The internal audit programme is implemented, with improvements made where required. The health and safety system meets current requirements.

There is a process for the recruitment, induction, education and performance monitoring of staff. The annual education programme is being implemented. There are a sufficient number of staff, and management, on site each day.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Needs Assessment Service Coordination (NASC) team assess residents prior to entry to confirm their level of care. Assessments and care plans are completed and evaluated by the registered nurse (RN).

Activities plans are completed by the (RN) in consultation with the activities coordinator. Planned activities are appropriate to the residents’ assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management policy in place. The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards 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. Trial evacuations are conducted as required.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The organisation has policies and procedures that support the minimisation of restraint. There were no residents using restraints or enablers on the day of the audit. The use of enablers is voluntary for the safety of residents in response to individual requests. Staff education on restraints, enablers and the management of challenging behaviour is provided.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Some standards applicable to this service partially attained and of low risk. |

There is a documented surveillance programme with is appropriate to the size and scope of the service.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 10 | 0 | 2 | 5 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 2 | 6 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and procedure meets consumer right legislation. Complaint forms are available at the entrance to the facility. These were translated into Mandarin/Cantonese. All complaints are being investigated by the assistant manager. All residents and family members interviewed confirmed that they have been actively encouraged to express any concerns and would not hesitate to approach management with a complaint/concern.  The previously identified areas of improvement have been addressed. The complaints register has been maintained. There had been eight (8) verbal concerns, and no written complaints for the year to date. All verbal complaints were addressed by the assistant manager in a timely manner. One of the complaints required involvement with the registered nurse, and the resident’s care plan had been updated accordingly. All concerns had been resolved to the satisfaction of the resident/family member. There have been no complaints to external authorities. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There are policies and procedures regarding access to interpreting services and open disclosure. An independent interpreter worked with the auditors during the audit. All residents are of Chinese descent and speak either Cantonese or Mandarin. There are no residents who speak English. All staff are of Chinese descent, some of whom can speak English. All information regarding services and resident rights is available in Mandarin/Cantonese. Staff and family members are able to interpret for the residents and family interviewed confirmed that there is sufficient communication from the managers’/staff and the registered nurse. Resident records sampled confirmed that the resident was informed in the event of a medication error. Family contact sheets are maintained and there was some evidence that family were contacted following an event or change in the residents’ health status. The previous area requiring improvement in relation to informing families following incidents remains open (refer reference to previously identified improvement in standard 1.2.4.3).  Residential agreements clearly describe services which are included as part of the agreement. All rest home resident had a signed agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation is owned by the directors with the managing director having a role in operational management and leadership. The role of assistant manager has been in place since 2018. The assistant manager is on site five to six days a week, and available on call. The organisation is a member of the Care Association New Zealand (CANZ) and the assistant manager attends CANZ meetings regularly in order to maintain educational opportunities and remain up to date with trends in the aged care sector. The assistant manager also attends meeting with a district health board (DHB) representative for managers of Chinese aged care facilities. The assistant manager has exceeded the required eight (8) hours training this year. Topics attended have included wound awareness, cognitive exams, and falls prevention, food care introduction to sarcopenia, immunity and nutrition. The assistant manager and managing director are supported by a registered nurse who provides 10 hours on-site per week and is available on call.  The philosophy is documented and reflects a focus on retaining as much independence as possible for each resident and on quality of care. A business plan for the organisation is documented and has not changed since the last audit. The purpose, values, scope, direction, and goals of the organisation are identified and reviewed.  There are 27 rest home beds available. On the day of audit there were 22 residents in the facility under the age-related residential care services agreement and six boarders. There were no residents under any other contract and no residents under the age of 65 years. Two of the boarders have recently been assessed by the needs assessment service to transfer into rest home level care. This will increase the number of rest home level residents to 24. At the time of the audit, the organisation was waiting on the final documents to be provided by the needs assessment service. The organisation has also converted the previous laundry into a double bedroom to accommodate a couple (refer identified improvements required in standards 1.2.4 and 1.4.7). |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The quality and risk management system has not changed since the last audit. The system is purchased from CANZ which ensures it remains compliant with requirements. This includes the required policies and procedures and a basic quality programme including the development of business/quality goals and the collation of quality data. The risk management programme includes monitoring of financial accounts, clinical risk assessments, health and safety procedures and hazard identification/monitoring.  Organisational performance is monitored through concerns/complaints; review of adverse events; monitoring of resident wellbeing and implementation of the internal audit programme. Staff meetings are conducted monthly. Minutes of meetings sampled confirmed discussions regarding collated quality data, proposed correction actions or changes to service or processes.  An improvement is required regarding resident satisfaction surveys. |
| Standard 1.2.4: Adverse Event Reporting  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. | PA Moderate | There is a process for reporting adverse events. This includes completion of an adverse events form, which is investigated and signed off by the assistant manager. The adverse event reporting process is included in staff orientation. All adverse events are added to a monthly register. Records sampled confirmed that the largest number of adverse events is falls, many of which are unwitnessed. An analysis of events is completed annually. This includes an analysis on hospital admissions, falls, challenging behaviour and infections. The 2019 analysis was well documented demonstrating that the number and type of events is consistent with those expected in a rest home setting.  The previously identified area of improvement regarding notification to the Ministry of Health regarding the change in management has been addressed and was closed out by the DHB representative, however notifications were not made regarding the reconfiguration of bedroom numbers. The other area of improvement regarding adverse event documentation has not been fully met. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | Policies and procedures for human resource (HR) management are documented and meet employment legislation. These are provided by an external consultant. Staffing is made up of health care assistants, kitchen staff, cleaning/laundry staff and an activities coordinator. Some staff work both in domestic duties and care giving. The assistant manager is responsible for HR management. This includes recruitment, orientation, education and staff monitoring processes.  Staff records sampled confirmed that the required employment agreements, position descriptions, education and staff performance were in place. Reference checks were completed if the applicant was not known to management.  It was reported that staff did not need any experience in the aged care sector prior to appointment. All staff are required to complete an orientation programme and caregivers are paired with a senior caregiver until they demonstrate competency on a number of tasks including personal cares. Caregivers confirmed their role in supporting and buddying new staff.  The organisation has an annual training schedule. This is a comprehensive programme and includes all requirements. Training is predominately provided by the assistant manager who has developed a number of quizzes to assess competency. In the event the staff member cannot attend staff training sessions, these are provided on a one-to-one basis. The content of each session is retained along with documentation of attendance. Education and training hours are at least eight hours a year for each staff member.  An improvement is required regarding the employment/orientation process of the registered nurse. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy has not changed since the last audit. Staff rosters sampled confirmed that there is always one caregiver on each shift, and additional staff on call as required. The managers are onsite most days of the week and on call. The registered nurse is onsite 10 hours a week and on-call at all times. Residents and families interviewed confirmed staffing was adequate to meet the residents’ needs.  The previously identified area of improvement has been addressed. There was previous concerns that there was not enough staff on the morning shift. This was resolved by the assistant manager coming in early each day to complete medication rounds in the morning and at lunch time. This has reduced the number of responsibilities for morning staff who are now more available to complete morning shower routines and additional personal cares. There is a designated activities person on site from 10am to 2pm Monday to Friday and some of the domestic staff are also trained health care assistants. There was no evidence to support that incidents were occurring due to lack of staff. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medicine management policies and procedures clearly outline the service provider’s responsibilities in relation to all stages of medicine management. Medications were stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the registered nurse (RN) when the resident is transferred back to service from hospital or any external appointments. Medication competencies were completed annually for all staff administering medication. There were no residents self-administering medicines at the time of the audit. Self-administration medication policy and procedure is in place when required.  The previous corrective actions relating to checking and returning as required (PRN) medicines to the pharmacy and completing six-monthly checks of controlled drugs were addressed. Additional improvements are required to the management of PRN medication and documentation of medication reviews. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The interpreter supported the auditor for interview of staff and review of documentation for the kitchen services since the available cook could only speak Cantonese and Mandarin. Meal services are prepared on site and served in the allocated dining room. The facility employs three cooks who work on different days of the week. The menu was currently due for review by the registered dietitian and was last reviewed October 2018. There is a four-weekly rotating summer meal menu in place. Diets are modified as required and the cooks confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents’ weights were monitored monthly and supplements were provided to residents with identified weight loss issues. The residents and family/whanau interviewed acknowledged satisfaction with the food service.  The kitchen was registered under the food control plan and the registration expires on 7 August 2021. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates were on all containers. Records of food temperature monitoring, fridges and freezers temperatures were maintained. Regular cleaning is conducted. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Interventions in the service delivery plans were relevant to address the assessed needs and desired goals/outcomes. All significant changes were reported in a timely manner and prescribed orders carried out. The RN reported that the GP’s medical input was sought in a timely manner that medical orders were followed, and care is person centred. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  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. | FA | The planned activities are meaningful to the residents’ needs and abilities. The activities are based on assessment and reflect the residents’ social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Residents’ files sampled reflect their preferred activities and were evaluated regularly or as when necessary. The activities coordinator develops a monthly activity planner which covers activities for the rest home and borders. These were posted on the notice boards in residents’ native language to remind them of upcoming activities. Residents’ activities information was completed in consultation with the family during the admission process.  The residents were observed to be participating in a variety of activities on the day of the audit. There are planned activities and community connections that are suitable for the residents. There are regular outings for all residents but due to Covid-19 most activities were in-house during the lockdown period. Residents and family/whanau interviewed reported overall satisfaction with the level and variety of activities provided.  The previous corrective actions relating to activities care plans not being individualised was addressed however activity care plans were not in sync with interRAI assessments and this remains partially attained (Refer 1.3.3.3). |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long-term care plans, interRAI assessments and activity plans were evaluated at least six monthly and updated when there were any changes (Refer 1.3.3.3). Resident care is documented on each shift by care staff in the progress notes. The registered nurse completed progress notes weekly and as necessary. All noted changes by the care staff were reported to the RN in a timely manner. Relatives and staff were involved in the care planning process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans were developed when needed and signed and closed out when acute problems have resolved. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The current building warrant of fitness was sighted and expires in May 2021. Records of the most recent building inspection noted the reconfiguration with reference to reduced emergency exits (refer identified improvement in standard 1.4.7). The remaining environment is safe and appropriate to the needs of the residents. Hazards are identified and there are safe outdoor areas for the residents to enjoy. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate | All staff receive training on fire and emergency procedures during orientation, and thereafter in an ongoing manner. This includes in-service training and attendance at trial evacuation drills. There are documented processes for the management of emergencies, with sufficient equipment and supplies readily available. The building includes smoke stop doors, identified emergency exits and a sprinkler system. There are fire distinguishers throughout the facility. There is a call bell system with call bells in bedrooms and bathrooms. There are first aid kits and all staff are required to have current first aid training.  An improvement is required regarding an approved evacuation plan. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Low | Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. There was evidence that the infection control surveillance programme was reviewed in 2019, however an improvement is required to ensure 2020 data is included in the programme. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies and procedures on restraint and enabler use, written information for residents and families on restraint and enabler use was sighted. The RN is the restraint coordinator. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures, practice, role and responsibilities. The RN interviewed reported that there was no restraint or enabler in use at the time of audit, and there has been no practice of using restraints or enablers at the facility. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Low | Routine internal audits are conducted. The internal audit programme includes two (2) to three (3) internal audits per month and covers the scope of the organisation. Supplier audits are also conducted. There was sufficient evidence that these audit are providing a method to monitor achievement against the quality goals and compliance. Corrective actions were documented and communicated to staff as required.  The organisation had previously included resident satisfaction surveys as quality data. Resident satisfaction surveys have not been completed since 2018.  Resident meetings also ceased during the COVID-19 pandemic. It was reported that residents did not feel they needed to have resident meetings during this time. Residents and family reported that they felt comfortable to give feedback to management at any time, and that their concerns/feedback would be taken into consideration. | Satisfaction surveys have not been completed as required. | Commence satisfaction surveys.  180 days |
| Criterion 1.2.4.2  The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Moderate | The provider converted the previous laundry to a double bedroom to accommodate a couple (refer identified improvement in standard 1.4.7). The bedroom was sighted by the auditor and deemed appropriate. The residents were happy with their room. This has increased the number of bedrooms by one and has not impacted on the total number of rest home residents allowed, however the required notifications were not made. This was discussed with the DHB representative at the time of the audit. | Essential notifications to the correct authority have not been made as required. | Confirm an understanding of situations which require an essential notification.  30 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Incident reports were sampled for the year 2020 to date. This included records of falls, challenging behaviour and medication errors. All incidents had been added to the monthly register. The assistant manager ensured that family were always notified, and this was confirmed in interview with family members, however full documentation for each incident was difficult to find. For example, there was inconsistent records of family being contacted, of progress notes being updated, the required observations being completed in the event of an unwitnessed fall and sign off by the authorised person. | Records of adverse events have not been consistently maintained. | Maintain all required records of incidents.  30 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | A new registered nurse was employed in October 2019. The registered nurse had no previous experience working in the aged care sector. It was reported that the nurse was orientated to the role by the previous registered nurse. The nurse’s employment agreement and current practicing certificate was sighted, however additional records regarding interRAI training, education relevant to the role, competencies and orientation were not available. | There was insufficient evidence to support the appropriate appointment of the registered nurse. | Provide evidence that the registered nurse is suitably qualified, trained and orientated to the role.  30 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Allergies were clearly indicated, and all residents’ photos were current for easy identification. All expired medications were returned to the pharmacy in a timely manner. The health care assistant (HCA) was observed administering medicines following the required medication protocol guidelines and legislative requirements. The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted. Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal were reported and attended to promptly. The GP reviews medications every three months and as required however this was not being consistently documented. The outcomes of PRN medicines administered were not being consistently documented. | Three monthly medication reviews were not being completed and the effectiveness or outcomes of PRN medications administered were not always documented. | Provide documented evidence of three-monthly medication reviews and evaluation of administered PRN medication  90 days |
| 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. | PA Moderate | InterRAI assessments and long-term care plans were completed within three weeks of admission by the RN. Subsequent six monthly interRAI assessments were not in sync with long-term care plans and activity plans. Residents’ care plans were developed in consultation with residents, family/whanau, and care and activities staff. This was confirmed by family/whanau in interview conducted. Evidence of this was sighted in the residents’ files sampled. | Long term care plans and activity plans were not in sync with six-monthly interRAI evaluations. | Provide evidence that interRAI assessments are in sync with long term care plans and activity plan evaluations.  90 days |
| Criterion 1.4.7.3  Where required by legislation there is an approved evacuation plan. | PA Moderate | In response to an increase in demand, the provider had chosen to convert the laundry into a double bedroom for a couple who required rest home level care. The laundry was now outside, under cover and in a controlled environment. When the laundry was inside it was one of the emergency exits and was still identified as an emergency exit on the approved evacuation plans displayed throughout the building. This emergency exit was blocked off by the provider when they converted the room into a bedroom, thus reducing the number of emergency exits from four to three. The fire evacuation plan had not been updated, and a new approval had not been sought from the fire department. The last approved fire evacuation report was in 2013. The laundry conversion occurred in September 2020 and was noted in the current building warrant of fitness inspection. The fire department and the DHB representative were contacted within 24 hours of the audit, with the provider being required to report to the DHB daily until the situation has been resolved. | The fire evacuation plan has not been updated or approved following the conversion of the laundry to a bedroom | Obtain an approved evacuation plan.  7 days |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | PA Low | A register in individual infections is maintained in the residents’ records, however the monthly collation and analysis of infection data has not been occurring. | Infection control surveillance data has not been gathered for 2020. | Implement the infection prevention and control surveillance programme.  30 days |

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

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| No data to display |

End of the report.