Dargaville Aged Care Limited - Norfolk Court Home and Hospital

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:	Dargaville Aged Care Limited
Premises audited:	Norfolk Court Home and Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 10 February 2021 End date: 11 February 2021

Proposed changes to current services (if any): None at time of re-certification audit. The above organisation is currently in the process of being sold and the planned settlement date is the 11 May 2021 and takeover proposed for 12 May 2021. A provisional audit (four hours) was arranged on 8 April 2021 onsite by DAA group Ltd, to re-verify findings of above audit and to record any changes that may have occurred in the interim time since the previous audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 53

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.

General overview of the audit

Norfolk Court Rest Home and Hospital Limited provides rest home, hospital and dementia level care for up to 57 residents. There have been minor changes to the organisation structure of the organisation since the last certification audit. The organisation demonstrates an ongoing commitment to continually review and improve services.

This combined audit was conducted to assess compliance against all the requirements of the Health and Disability Services Standards and the provider's contract with the district health board (DHB).

The audit included interviews with management, residents, staff, family members and the general practitioner (GP). Policies, procedures, records and documents were reviewed and sampled. Observations were included.

There was one area identified as requiring an improvement. This relates to the care planning process.

A provisional audit 08 April 2021 was arranged by the prospective buyer to be undertaken to re-verify the accepted certification report by HealthCERT. The prospective buyer is well prepared and has a transitional plan developed to cover the business, management and service provision to ensure a smooth handover when the sale is finalised. The one area identified for improvement in the previous audit has been addressed by the service provider. There were no new areas of improvement identified at this site audit.

Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Documented procedures, interviews with residents, family members and staff, together with observation confirmed that residents' rights are understood and met in everyday practice. Communication channels are defined and interviews confirmed communication is effective. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Residents are free from discrimination and have access to advocacy services. Reports or allegations from residents regarding concerns are followed up and remedied in a timely and appropriate manner. Resident meetings occur and the managing director has an open-door policy.

Informed consent requirements are clearly defined and residents and staff members interviewed confirmed choice is given and informed consent is facilitated. Links with community resources are supported and facilitated. Visitors are free to come and go as requested by the residents. The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

Resident interviews confirmed understanding of their right to make complaints if necessary. A complaints register is maintained. Complaints are used as an opportunity to improve services.

Organisational management

The rest home and hospital is currently privately owned and governed by two directors, one of whom is the managing director (MD). The purpose, values, scope, direction and goals of the organisation have been reviewed and key targets are monitored. The MD is supported by the clinical nurse manager (CNM).

The organisation has a quality and risk management system that is monitored and reviewed to generate improvements in practice and service delivery. The required policies, procedures and work instructions are in place and accessible. Key quality goals are defined and achievement towards these goals are reported and communicated during regular meetings. The organisation implements an internal monitoring programme. Corrective actions are developed where a short fall is identified. Risks are identified and managed accordingly. The adverse event reporting system is managed well.

Human resource management and employment policies are in place. There is a system for validating professional qualifications. Staffing is appropriate to meet the needs of residents over the 24 hours with experienced advice and assistance available. There is an in-service education programme.

Resident information is securely maintained, integrated, current and up to date.

Continuum of service delivery

Policies and procedures provide guidelines for access to service. Residents are assessed prior to entry to the service to confirm their level of care. The nursing team is responsible for assessment, development and evaluation of care plans. Care plans are individualised and developed in consultation with residents and family/whanau.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP) and these were current. Staff involved in medication administration are assessed as competent.

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours.

Safe and appropriate environment

The facility is appropriate to the needs of the residents and is purpose built. All equipment was observed to be in good working order. Well-furnished lounges, dining and external areas are accessible to all residents. The dementia unit (the Haven) is secure and has a well-equipped secure outdoor area. The facility has plenty of natural light and is maintained at a comfortable temperature. Bedroom areas are sufficient in size to allow for personal possessions and to accommodate mobility aids, equipment and staff caring for the residents. Toilet, shower and bathing facilities are sufficiently equipped. Applicable building and fire regulations are met.

Cleaning and laundry services meet infection control requirements and are of a good standard. Collection, storage and disposal of waste is in accord with infection control principles. Staff comply with safe waste and hazardous substances processes.

Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. The organisation has appropriate stores and equipment in the event of a civil defence emergency or a pandemic.

Restraint minimisation and safe practice

There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were 12 residents using restraint and none using enablers at the time of the audit. Staff interviewed were knowledgeable on the use of restraints and enablers and receive ongoing restraint education. Environmental restraint is in place for residents in the secure dementia unit in the form of coded locked doors however visitors come and go as they please.

Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. The infection control programme is reviewed annually.

Infection data is collated monthly, analysed and reported. The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported in a timely manner.

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	49	0	1	0	0	0
Criteria	0	100	0	1	0	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies reflect the Code of Health and Disability Services Consumer Rights (the Code). The Code is included in the orientation of all new staff and staff interviewed demonstrated knowledge of the Code. The Code is also discussed as part of the annual in-service education programme. Residents and relatives interviewed, and observation during the audit, indicated that staff understand resident rights and their responsibilities and that resident rights are observed in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The consent policy and procedure references consumer right legislation, including competency/mental capacity. There is also a policy on advanced directives. Nursing and care staff interviewed understood the principles and practice of informed consent. Clinical files sampled confirmed that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA), or residents, and the general practitioner makes a clinically based decision on resuscitation authorisation if required. Staff were observed to gain consent for daily

		cares. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are informed of their right to access independent advocacy services. Information is readily available. A representative from the National Advocacy Services visits the facility and provides staff training on advocacy issues. Complaint records sampled confirmed the involvement of a member of the National Advocacy Service. Residents and staff understood the resident's rights to have a support person of their choice.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family/ whānau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family/ whānau and friends. Family/ whānau interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.
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 the requirements of consumer rights legislation. Residents and family confirmed access to the complaints procedure. Complaint forms are readily available, as are the contact details for advocacy services. A complaints register is maintained. This includes the nature of the complaint, actions and outcomes. Complaint records confirmed both written and verbal complaints were managed as per legislative requirements. All had a full investigation and follow up letter to the complainant. There was also evidence that any concerns shared at resident meetings, or in surveys, were followed up appropriately. An analysis of complaints, including trends and outcomes has been completed by the MD. One complaint was forwarded to the Health and Disability Commissioner in 2020. This was referred to the National Advocacy Services and has been resolved to the satisfaction of the

		complainant. The full investigation and related reports were sampled.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family/whānau and residents interviewed were aware of consumers' rights and confirmed that information was provided to them during the admission process. The admission pack outlines the services provided. Admission agreements signed either by the resident or by an enduring power of attorney (EPOA) were sighted in records sampled. Admission agreements meet the district health board requirements. Provisional audit 8 April 2021: The prospective provider representative interviewed has a good knowledge of the Health and Disability Consumer Rights (the Code) and how to ensure this is well implemented into aged residential care services. In addition to understanding the Code the prospective buyer representative is fully informed about the Nationwide Health and Disability Advocacy Service and how to contact this service for a resident and/or family if required.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There is a policy and procedure regarding resident safety, neglect and abuse prevention. This includes definitions, signs and symptoms and reporting requirements. There are also policies regarding protection of vulnerable adults, sexuality and intimacy. These provide guidelines on respect, safety and privacy. Guidelines on spiritual care to residents are also documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/ whānau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice. Residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with residents assessed as rest home, hospital and

		dementia level of care. Residents from the rest home and hospital areas were able to move freely into the surrounding areas and in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	There is a policy on cultural awareness. This references the Treaty of Waitangi and Ministry of Health (MOH) Māori Health Strategy. The organisation tries to reduce barriers to access by ensuring a culturally appropriate environment and staff awareness. Signage around the facility is displayed in both English and Te Reo. There is an assessment for Māori residents. Cultural needs are included in the care plans, if identified. There is access to cultural advice, resources and documented procedures to ensure recognition of Māori values and beliefs. The organisation maintains contact and input from a local Māori disability services. There were nine (18%) staff and five (10%) residents who identify as Māori. Māori staff confirmed that the services provided were in line with the needs of Māori and the local community.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whānau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they are encouraged to be involved in the development of residents' care plans. Residents' personal preferences and special needs were included in the resident care plans sampled.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Family/ whānau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and this was confirmed by the residents. The induction process for staff includes education related to professional boundaries, expected behaviours and

		the code of conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The clinical nurse manager (CNM) stated that there have been no reported or alleged episodes of abuse, neglect or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The provider demonstrated a number of areas which are reflective of good practice. An internal nursing model of care has been implemented. This includes the role of the primary nurse, care plan interRAI nurse and clinical portfolios for restraint, medication, infection prevention and control and care plan development and review. The role of care giver shift leaders has also been implemented. It was reported that this has resulted in increased accountability and better communication channels. The managing director (MD), diversional therapist, clinical nurse manager and shift leaders meet every Monday morning to discuss the week ahead, individual client needs and any other impending issues. A team building and planning day has been developed and implemented for staff who work in the dementia unit (the Haven). This has resulted in improved systems, better staffing and consistency with a core staff of four to five. Good practice is also supported through ongoing professional development of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Policies and procedures are linked to evidence-based practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The Open Disclosure policy and procedure meets requirements including the key principles, responsibilities and an apology. There was evidence that family members were informed following events, or a change in the resident's status. Residents and family stated that they receive sufficient and current information from the organisation as required. Communication with family members was maintained during the COVID-19 lock down period, with family members stating that they

		were kept well informed. All residents and staff are able to communicate in English, with some Te Reo used as applicable. There is access to interpreting services if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Norfolk Court Rest Home and Hospital Limited is owned and operated by the two directors. One of the directors is the managing director (MD) and the other works as the administration manager. The MD has an extensive background in the management of health and disability services. The administration manager has a background in administration and accounts. The MD remains up to date with current trends in the aged care sector through attendance at regional provider meetings, frequent contact with other facility managers and the DHB, who have signed off all previous areas requiring improvement. The organisation has also been involved with the DHB with regard to scenario planning for COVID-19 outbreaks occurring in aged residential care facilities A current business plan/strategic review is documented. The strategic imperatives have been documented with associated goals for monitoring including actions and responsibilities. The mission statement is documented. A current organisational chart was sighted. Organisational performance is monitored through reports of inputs, outputs and quality activities. Financial reports are provided each month from the external accountant. Records of management meetings confirmed discussions on occupancy, marketing and sales, finances, information technology (IT), staffing, health and safety, adverse events and business planning. The rest home is certified to provide 63 residential beds, however the MD choses to not extend over 57 available beds. This includes 35 dual purpose beds (for residents requiring either rest home or hospital level care) and a 15-bed secure dementia unit (the Haven). A number of the dual purpose and rest home rooms can operate as double rooms if required. There were 52 residents on the day of the audit. This included 15 residents in the Haven, 14 residents in rest home level care, and 23 in hospital level care. Norfolk Court can also provide respite services, long term and short term stays if required. These beds were not occupied on

		the days of the audit. Provisional audit 8 April 2021: On the day of the audit 53 residents of a total of 57 beds were occupied. There were 15 rest home level care residents and 23 in hospital level care. There were no residents receiving respite care. There was one additional contracted DHB respite care bed which was not occupied. There were 15 secure dementia care residents in the Haven. The pre-determined lead in time is planned with a completion checklist for Norfolk Court Home and Hospital in place. The settlement checklist addresses the settlement requirements which cover conditions precedent, any pre-settlement obligations, settlement obligations identified and post-settlement obligations. The settlement date is 11 May 2021 and takeover date 12 May 2021. All legal requirements/obligations to be meet under the settlement agreement for sale and purchase of the business are documented. A transitional plan is developed and was reviewed. The prospective buyer/representative interviewed stated there are no immediate plans to make changes. Staff had been fully informed one week prior to this audit of the prospective sale of the business. The families and residents have also been notified by letter. The prospective provider stated that the Northland District Health Board has been notified of the sale of this service.
Standard 1.2.2: Service Management 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.	FA	The MD is supported by the clinical nurse manager (CNM). The CNM is an experienced registered nurse with management experience, has been with the organisation for 14 months and was recently appointed to the CNM role. The 'Lines of Communication and Formal Reporting' policy includes delegations to the CNM in the absence of the MD, however as the CNM is new to the role, the MD reports that business continuity insurance, and capacity in the business model would allow for additional management support in the event of a temporary absence. The MD has not scheduled any planned leave until the CNM has had time to be fully experienced in the role. Provisional audit 8 April 2021: The established transitional plans were reviewed and interview with the prospective buyer representative evidenced that no service management changes will be made. Staff

		changes, covering the roster and allocation of staff will remain unchanged. The prospective buyer will own the facility, but the interviewee will take on the role of the facility manager (FM). This role is not new for this person as the prospective buyer/representative has worked in aged residential care for about 15 years and more recently was FM at another aged residential care service for another organisation up until November 2020. The clinical nurse manager will continue in this role and is well supported by registered nurses.
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.	FA	There is a documented and implemented quality and risk management system which is compliant to requirements and based on a continuous improvement model. Ongoing work has continued to ensure that the required policies and procedures are documented and current. A report titled 'Implementing a new Organisation Policy System' has been written to ensure the quality and risk management system is personalised to the facility. There is a document control policy and procedure. A clinical quality initiatives plan has been documented in measurable terms. This includes quality statements and goals with a review of the achievements in the previous year. The MD maintains a comprehensive schedule of all monitoring and performance requirements. This includes the implementation of routine, and extraordinary, internal audits. All audits include recommended corrective actions with repeated audits to measure the successfulness of these. The organisation is also registered with a benchmarking group for the Northland area where clinical indicators are set and measured on a monthly basis. This was placed on hold during the COVID-19 pandemic. Quality team member's guidelines and reporting tools are documented. Quality related data is collated and trends identified. Quality data is discussed in a range of forums including the management team meetings, clinical quality group meetings, nurses meetings and health and safety meetings. Resident satisfaction surveys were last conducted in March 2020. The collated results confirmed a high level of satisfaction. There is evidence that any concerns have been addressed, for example a restructure of the activity programme. Staff satisfaction audits were also completed in 2020 which confirmed general

		satisfaction. A risk management framework and register is documented. Risk management process is discussed in the business plan. A significant risk to the organisation has been the ongoing difficulties regarding recruitment and retention of registered nurses. Strategies to minimise this risk are frequently discussed with the DHB, and the MOH were informed. There is evidence of risk monitoring in meetings minutes sampled. There is a current health and safety management system with health and safety representation throughout the organisation. Recent health and safety meeting minutes confirmed discussions regarding pandemic planning, emergency planning, environmental assessment and hazards. Provisional audit 8 April 2021: All policies and procedures were current and meet legislative requirements to meet the health and disability sector standards and continuous quality improvement. Meeting timeframes have been arranged for the year and the educational calendar is developed and implemented. This will continue as planned for 2021. The internal audit schedule for 2021 was reviewed. Continuity of service provision is being encouraged by management and staff during this transitional time. Registered nurses have recently taken on 'champion' roles and will complete relevant internal audits, will arrange the annual and six monthly restraint reviews and provide ongoing education for staff. The RNs will report to the CNM monthly or earlier if any issues arise. The prospective FM/representative explained that the quality and risk management plan will be reviewed at the time of takeover as needed and in consultation with the new owner/director. Planning of activities that will contribute to continuous quality improvement will continue and the only possible change would be to increase Monday to Sunday RN cover in the dementia service and to have two caregivers on duty at night-time instead of one caregiver as per the current roster reviewed.
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	FA	There is a policy and procedure on adverse events. This includes reporting, collating, trend analysis and reportable events. The policy references the open disclosure process. All staff have access to incident

where appropriate their family/whānau of choice in an open manner.		and accident reporting forms. Clinically related incidents and accidents are forwarded to the CNM with all others forwarded to the MD. Incidents and accidents are monitored by type, time and location. This provides sufficient data to identify trends and develop targeted corrective actions. Data on all incidents and accidents is reported at clinical quality group meetings, health and safety meetings and management meetings. A full monthly analysis of all adverse events for was sighted. Progress notes sampled confirmed that the required records had been documented and family contacts made. The required first aid and routine observations were applied for all clinically related events. For example, neurological observations following an unwitnessed fall. Provisional audit 8 April 2021: There are currently no legislative or compliance issues that are impacting on the service at the time of the audit.
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.	FA	There are policies and procedures in relation to human resource management which comply with current good employment practice. There is a process for recruitment screening and the validation of professional qualifications. Staff receive an orientation to the facility and to their respective role. The orientation programme includes the essential components of service delivery, including emergency procedures. A buddy programme is implemented and records of buddy training are maintained. There is an additional checklist for the registered nurses and staff who work in the dementia unit. There is a health and safety induction training. The new CNM received a month's handover into the role and is engaged to be mentored by a CNM from another aged care facility. The skills and knowledge required for each position is documented in position descriptions. Position descriptions outline accountability, responsibilities and authority. The role of care giver shift leaders has been introduced. Shift leaders provide more leadership and accountability to the care giver team, with quicker decision making made on the floor. There were five shift leaders appointed at the time of the audit. Shift leaders are required to have completed level three or four health and wellbeing training.

		The staff training policy and procedure includes the required DHB topics. The 2021 training plan was sighted. There is mention of the additional training required to work in the dementia unit. Care givers are required to commence the national certificate in working in aged care within six months of commencement. Staff working in the dementia unit have either commenced or have completed the required dementia related qualifications. Of the 30 care givers, 13 have completed level one, three have completed level two, 10 have completed level three, four have completed level four, and an additional nine staff are enrolled at various levels. Medication competencies are maintained for those who require them. The nurses also complete phlebotomy and syringe pump training. There are three registered nurses who are interRAI competent. All staff are required to have current first aid certificate, with some staff currently enrolled for updates. Records of education and attendance are maintained with good to average attendance from staff. The staff appraisal policy and procedure requires annual performance reviews. Annual performance reviews were sighted in all staff records sampled. Provisional audit 8 April 2021: The prospective buyer/representative interviewed stated that there will be no changes in employment practice and all legislative requirements will be met. The current staffing of the facility will not decrease at time of handover. As mentioned in 1.2.8 the only proposed increase will be to cover the dementia service with an additional caregiver at night-time and increase the RN to cover Monday to Sunday in the dementia service. Since the previous audit, one further RN is now fully trained and has current interRAI competencies. Since the certification audit, a further two caregivers are completing New Zealand Qualifications Authority (NZQA) level 4 qualifications, two are completing level 3 and five are completing level 2 training. Four staff have expressed interest and are waiting to be enrolled in external training provided. The registered nurses and some senior caregivers who administer medicines have completed annual medication competencies and these were reviewed. Two registered nurses are enrolled to complete the phlebotomy training with the laboratory service.

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 organisation employs 37.67 full time equivalent staff. The total number of staff is 51. This is a combination of management, registered nurses, care giver shift leaders, care givers, administration staff, housekeeping and maintenance staff. The largest group of employees is care giver staff with a total of 30. There are currently six registered nurses, plus the CNM. There is a policy titled 'Roster Setting & Working According to Rostered shifts'. This outlines how the rosters are developed. Reports have also been developed to include the 'System for Managing Rostered Care Giver and Nursing Hours' (August 2020) and 'Roster Management Guidelines for Nurses' (May 2020). Current staffing numbers meet contractual requirements. There is a one registered nurse per shift plus the CNM during business hours Monday to Friday, and on call. The registered nurses have also been allocated additional shifts per week to address clinical pathways and quality improvement tasks such as creating, updating and reviewing care plans and interRAI assessments. A registered nurse is also rostered a shift to attend the weekly GP clinic. The number of caregivers rostered per shift is sufficient. Shift leaders are rostered on all morning and afternoon shifts. There is always two qualified and experience staff members rostered in the Haven during the day, with access to additional care staff and a registered nurse during the night if needed. There is always more than one staff member rostered who has a current first aid certificate. Rosters were sampled to ensure appropriate numbers of staff and cover in the event of a temporary absence. Care staff have the opportunity to swap shifts on the condition they swap with another staff member with similar skills and experience. Records of shift swaps were sighted in the communication book and approved on the shift change request form. Reconciled entries in the communication book with the amended rosters confirmed sufficient cover is being provided. Provisional audit 8 April 2021: The CNM was interviewed. There is a policy in place to meet the requirements for staff coverage as per the services agreement with the DHB. The design of the facility and the needs of the residents are considered when setting up the rosters and allocating staff to all the service areas. In the dementia service there is

		always a staff member on duty who has completed the required dementia care training as per the service agreement obligations. The only suggested change from the prospective provider representative is to increase the caregiver coverage to two caregivers in the dementia service at night-time and to increase, if possible, the registered nurse coverage to seven days a week in Haven.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	There is a policy and procedure on records management. Records of current and previous residents are securely maintained. Residents' demographic information is documented on entry. The admission assessment includes verification and documentation of individual resident information. Residents' records sampled included reports from all health professionals. Records are integrated in the one file. Entries were legible, dated, signed and designated. Progress notes are maintained as required. Archived records are safely stored.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The entry to service policy includes all the required aspects on the management of enquiries and entry. These include, Needs Assessment Service Coordination (NASC) assessment, discharge summary and other required documents. Assessments and entry screening processes are documented and clearly communicated to the residents, family/whānau where appropriate, local communities and referral agencies. Records sampled confirmed that admission requirements were conducted within the required time frames and are signed on entry. Family/whānau and residents interviewed confirmed that they received sufficient information regarding the services to be provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital and the organisation's transfer discharge form to another service. Residents and their family/whānau are involved in all exit or discharges to and from

		the service and there was sufficient evidence in the residents' records to confirm this.
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.	FA	There is a comprehensive range of medication management policies and procedures. Policies include a reference to the Ministry of Health 2011 Medicines Care Guides for Residential Aged Care. The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medications were stored in a safe and secure way in the trolley and locked cupboards. Stocked medication is only available to residents requiring hospital level care. Medication reconciliation is conducted by the RNs when the resident is transferred back to service from hospital, appointments, or when there are any medication changes. All medications were reviewed every three months and as required by the GP. Allergies were clearly indicated, and photos current for easy identification. An annual medication competency was completed for all staff administering medication. The RN and caregiver were observed administering medicines in their respective wings and followed the required medication 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 was conducted regularly and deviations from normal were reported and attended to promptly. All expired medications were returned to the pharmacy in a timely manner. There were two residents self-administering medicines and were assessed as competent. A self-medication policy is in place. Medication administration records were maintained.
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 residents have a dietary profile developed on admission which identifies likes and dislikes and is communicated to the kitchen including any recent changes made. Residents are provided with alternative meals when needed. Diets are modified as required and the cooks confirmed awareness on dietary needs of the residents. The menu is

		reviewed by the registered dietitian every two years and due for review in March 2021. There is a four-weekly rotating winter and summer menu. Meal services are prepared on site and served in the allocated dining rooms. Meals are served warm in sizeable portions and any alternatives are offered. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night. The family members and residents interviewed acknowledged satisfaction with the food service. The food services internal audit for the year 2020 confirmed satisfaction with the food provided. The kitchen was registered under the food control plan and the registration expires 13 April 2021. The kitchen and pantry were sighted and observed to be clean, tidy and well stocked. Labels and dates were on all containers. Records of food temperature monitoring, fridges and freezers temperatures were maintained. Regular cleaning is conducted. Staff who work in the kitchen have all received the relevant training.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	The CNM and the administrator reported that all consumers who are declined entry are noted. Reasons for refusal are explained. When a prospective resident is declined entry, family/whānau and the prospective resident are informed of the reason for this and made aware of other options or alternative services available. They are referred to the referral agency to ensure that they will be admitted to the appropriate service provider. All outcomes of entries were recorded on the resident information form.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	Residents had their level of care identified by the assessment agency. Family/whanau and residents interviewed expressed satisfaction with the assessment process. An improvement is required to ensure the outcomes of interRAI assessments/updates are addressed in the service delivery plans.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The care plans sampled were resident focused and individualised. Short term care plans were used for short-term needs. Family/whānau and residents interviewed confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals' involvement in the care of the residents such as the mental health services for older people, district nurses, physiotherapist, podiatrist, dietitian and GP. Short term care plans were developed and reviewed as required. The assessment findings are required to inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. Refer required improvement in criterion 1.3.4.2 regarding the assessment findings.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	All care plans sampled confirmed that interventions were adequate to address the current needs of residents. Significant changes were reported in a timely manner and prescribed orders carried out. The CNM reported that the GP's medical input was sought within an appropriate timeframe that medical orders were followed, and care was person centred. This was confirmed by the GP. 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 residents reported that the planned activities are meaningful to them. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Residents' files sampled reflected their preferred activities and were evaluated, however outcomes from interRAI assessments were not consistently included in the activity care plans (Refer 1.3.4.2). The activities coordinator is assisted by an assistant activities' coordinator. The activities coordinator develops a monthly activity planner which covers activities for the rest home, hospital and dementia level of care residents. These were posted on the notice boards to remind residents 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 days of the audit. There are planned activities and community connections that are suitable for the residents. The service has worked with the Alzheimer's society who had arranged an Alzheimer's day once a week where residents have a chance to meet with other members of the community for activities at the facility. This has not been happening frequently due to low turnout by the community members however the service has continued meeting with residents at the facility. There are regular outings for all residents. Residents and family/whānau interviewed reported overall satisfaction with the level and variety of activities provided. Residents from the dementia unit frequently join other residents for activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is documented on each shift by care staff in the progress notes. All noted changes by the care givers were reported to the CNM and registered nurses in a timely manner. Formal care plan evaluations, following interRAI reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occurred every six months or as residents' needs change (Refer 1.3.4.2). These were carried out by the nursing team in conjunction with the family, the GP and specialist service providers. Where progress was different from expected, the service responded by initiating changes to the service delivery plan. Short term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews confirmed residents and family/whanau were included and informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or	FA	Residents and family/whānau are supported to access or seek referral to other health and/or disability service providers where required. If the need for other non-urgent services are indicated or requested, the GP, nurse practitioner and the nursing team sends a referral to seek

disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		specialist services assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses and GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to the public hospital in an ambulance if required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are guidelines on the management of waste and hazardous substances. Personal protective equipment is available throughout the facility. Domestic waste disposal meets council requirements and is removed from site as required. Infection control policies include the use of single use items. Chemicals and used products are securely stored or disposed of. Hazardous substances, for example oxygen cylinders are safely stored. All staff receive training on the use of personal protective equipment (PPE) and the management of waste and hazardous substances. Staff were observed using PPE correctly during the audit.
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 building is separated into three distinct areas. The Haven and three wings which can accommodate residents requiring either rest home or hospital level care. The outdoor area used by the residents in the dementia unit is secure and safe. There is adequate parking. Central corridors are wide enough to accommodate mobility equipment and aids. There are safe handrails and ramps. There is a current building warrant of fitness. Electrical testing is conducted. Medical equipment was last calibrated in May 2020. Furniture is provided and maintained in good order. There is a routine maintenance schedule which is being implemented as required. There is also evidence that ongoing maintenance requests are actioned in a timely manner. The maintenance work schedule was sighted. An annual environmental assessment of the building is completed by the health and safety committee. There is a maintenance person on site every morning and available on call. There is a documented and implemented health and safety programme. A health and safety statement is documented and displayed. All hazards

		are identified. These are discussed monthly by the health and safety committee. The committee meets bimonthly. The health and safety programme also includes a process for ensuring contractor safety when on site Provisional audit 8 April 2021: The facility manager and the CNM interviewed stated there were no plans at the time of the audit for environmental changes to the service that will need compliance with legal requirements. All building, plant and equipment complies with legislative requirements. The building warrant of fitness is displayed and is current at the time of the audit. The facility which is 29 years old is well maintained on visual inspection both internally and externally. There will be no changes to the fire evacuation scheme though this was recently reviewed for the sale of the facility. A staff fire drill was held on the 12 March 2021 and a report reviewed was sent to the New Zealand Fire Service.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are sufficient numbers of toilets, showers and bathing facilities. There is a combination of shared bathrooms and private ensuites. All rooms have a hand basin. Hot water is maintained at a consistent temperature which is checked monthly. Records of temperatures are maintained and any variations are corrected and reported to management. Residents and family members interviewed voiced no concerns regarding the toilet/bathing facilities, including maintaining privacy. There are staff and visitor toilets. The visitors' toilet is accessible to those who have a disability.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There are a number of rooms which can be used as double rooms if required, however there were no rooms being shared at the time of the audit. All residents' rooms are sufficient in size for personal items and equipment. Each room has a hand basin, cupboard, armchair and suitable bed to support care needs.
Standard 1.4.5: Communal Areas For Entertainment,	FA	All areas have adequate and well-furnished lounge and dining areas.

Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		These areas are well utilised and sufficiently sized. Private rooms can be used as low stimulus areas in the dementia unit. Residents and family members interviewed voiced no concerns regarding the communal and dining areas. The Haven has a shared dining and lounge area; however, the residents tend to access additional communal areas in other areas of the facility, supported by staff. For example, residents from the Haven were observed joining the activities programme provided in the rest home area on the days of the audit.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There is a comprehensive cleaning services and laundry manual. Cleaning and laundry services meet infection control requirements and are of an appropriate standard. The laundry has separation of clean and dirty areas. All laundry is completed on site and there are designated laundry staff. Day to day cleaning is completed by designated cleaners. Staff are trained at orientation in the use of equipment and chemicals. Documented guidelines are available and duty schedules for cleaning and laundry are provided for both day and night duties. Material data safety sheets are displayed. Cleaning and laundry hazards are documented. The MD has completed a review of cleaning and laundry processes. Cleanliness and laundry standards are monitored through internal audits, resident feedback and monthly resident meetings. Resident meeting minutes confirmed discussions regarding the satisfaction of cleaning and laundry services. Internal audits for the year 2020 confirmed implementation of any findings/recommendations. The facility is observed to be clean on the days of the audit. No hazardous chemicals were accessible.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. The fire service has approved the current evacuation plan. The MD choses to run evacuation drills every two months to ensure all staff are able to attend. Records of two monthly evacuation drills were sampled. Attendance

		records of evacuation drills included night staff members. The building is separated into six zones by fire doors. A smoke alarm system and sprinkler system is in place and fire extinguishers were easily accessible. Evacuation procedures are displayed throughout. The emergency management plan has been reviewed and a copy provided to the emergency planner at the DHB. This has been updated and reviewed to include COVID-19. Outbreak management and pandemic planning is current with sufficient supplies PPE, food, equipment and water in the event of an emergency. The building has emergency lighting in the event of a power failure, there is a BBQ, and the one stove in the kitchen is gas. All bed spaces, bathroom and toilets throughout the facility have a nurse call bell and these were seen to be within easy reach. The location of the call shows above the door of the resident's room. There is a security code on the door to the Haven and the section is fully fenced. Staff conduct a round of the entire facility in the evenings to ensure all doors and windows are secure. The front door locked is locked at 7pm. There are security lights outside. There have been no events related to security. All staff receive training in the management of emergencies which is included in orientation and in-service education. The last in-service was conducted in December 2020. This was confirmed in staff records and interviews.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The facility has plenty of natural light. All rooms have at least one good sized window. There is plenty of natural ventilation and sunlight. Interview with residents indicate that the internal environment is maintained at a comfortable temperature. There were no concerns voiced by residents, or family regarding the temperature of the facility. There is a designated smoking area outside which is away from the building.
Standard 3.1: Infection control management	FA	There is a designated infection prevention and control coordinator (ICC).

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.		The responsibilities and accountability for the role is clearly defined. The ICC reports directly to the CNM and the MD. The infection prevention and control programme is appropriate to the size and scope of the services and is reviewed annually. The programme has been reviewed and amended in light of the COVID-19 pandemic. Information regarding the steps to reduce the spread of infection are displayed throughout the facility. This includes information on handwashing. There was multiple signage at the entrance to the facility reminding all those who are unwell not to enter. There is also hand sanitiser and QR code at the entrance to the facility. All visitors have their temperatures checked and sign in on entry. The facility chose to lock down again during the recent community transmission in the Northland area. All residents and family were kept informed. Provisional audit 8 April 2021: The infection prevention and control programme is well implemented across all services. Protocols are in place to screen visitors on entry to the service. There is adequate personal protective resources and signage seen around the facility in all service areas. Additional stores are available for the event of a pandemic outbreak. A registered nurse has been appointed the infection control champion since the previous audit and reports to the CNM monthly. A job description has been developed and implemented for this specific role which is a positive quality initiative.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection prevention and control coordinator (ICC) have appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control. Additional support and information are accessed from the infection control team at the DHB and the GP as required. The CNM reported that the coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The CNM confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection.
Standard 3.3: Policies and procedures	FA	Comprehensive policies and procedures on infection prevention and

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.		control are documented. This includes a recently developed policy on COVID-19. Additional policies and procedures include PPE, outbreak management, hazardous substances, hand hygiene, waste management, cleaning and disinfection and surveillance activities. Staff were observed to be following the infection control standards comply with relevant legislation and current good practice. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICC is a registered nurse and provides infection prevention and control training for staff. Training and attendance records are maintained. The infection prevention and control training education information pack is detailed and meets required legislative and current regulations. Infection control is part of the orientation programme and all staff complete a hand washing pledge. Additional education has been provided on COVID-19.
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.	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. All results of surveillance and specific recommendations are to assist in achieving infection reduction and prevention outcomes. These are acted upon, evaluated and reported to relevant personnel and management in a timely manner. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The assessment, approval, monitoring and review process is the same for both restraints and enablers. An updated restraint register was sighted, and staff interviewed understood the difference between restraint and enablers. Risk minimisation was documented in the care plans of the residents and restraint was evaluated regularly. Approved equipment which can be used as a restraint includes, bedrails, lap belts and three-point harness. At the time of the audit there were 12 residents

		on restraint and two residents using enablers at their request for safety and comfort. The family and residents were informed about the restraint process and risks involved. All staff have completed a restraint minimisation competency during orientation. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation and review process.
Standard 2.2.1: Restraint approval and processes 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.	FA	A registered nurse is the designated restraint coordinator and is responsible for education of staff ensuring the restraint process is followed according to restraint minimisation and safe practice standards. The roles and responsibilities of the restraint coordinator are clearly defined and there are clear lines of accountability for restraint use. The approval process is in place and includes the RN, GP and a family representative. The required approvals were sighted in records of restraint. Restraint use is discussed in management, quality, RN and staff meetings.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The restraint coordinator undertakes the initial assessment with input from the resident's family/whānau/EPOA and GP. The restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members including the use of sensor mats and low beds which

		has already seen a reduction in restraint numbers. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are respected. A restraint register was maintained, updated every month and reviewed at each RN meeting. The register was reviewed and contained all residents currently using a restraint and enough information to provide an auditable record. Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Regular reviews are conducted on residents with restraints and this was evident in the records sampled. The GP confirmed involvement in the restraint review process. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring and any change required. Staff and family/whanau confirmed involvement in restraint use evaluations. The evaluation forms included the effectiveness of the restraint and the risk management plans were documentation in the long-term care plans. Evaluation time frames are determined by the risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service has demonstrated monitoring and quality review on the use of restraint. An internal audit was conducted regarding restraint use in 2020. This included a review of all restraint use and associated processes, including the policies and procedures. This resulted in a corrective action regarding care plan documentation. The corrective action and implementation was discussed at the monthly nurses meeting and the quality meeting. Restraint updates are routinely included in the monthly staff and quality meetings. Meeting minutes confirmed discussions on restraint are being

		conducted and included review of restraint use.

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)
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	Initial nursing assessments were completed on admission while residents’ care plans and interRAI assessments were completed within three weeks according to policy. Assessments and care plans were detailed and included input from the family/whanau, residents, and other health team members as appropriate. Additional assessments were completed when needed; this included pain, behavioural, falls risk, nutritional requirements, and continence, skin, and pressure injury assessments. The nursing staff utilised standardised risk assessment tools on admission. The outcomes/triggers from the interRAI assessment were not consistently included in the care plans, and activity plans, sampled.	Not all outcomes from interRAI assessments were included in the long-term care plans and activity plans.	Provide evidence that interRAI assessments outcomes are included in the long-term care plans and activity plans. 90 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.

No data to display

End of the report.