Bethsaida Trust Board Incorporated - Bethsaida Retirement Village

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 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:	Bethsaida Trust Board Incorporated
Premises audited:	Bethsaida Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 June 2021 End date: 1 June 2021

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: 51

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
	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

Indicator	Description	Definition
	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

Bethsaida retirement village provides rest home and hospital level care for up to 57 residents. The service is operated by the Bethsaida Trust Incorporated and managed by a facility manager and a clinical nurse manager. Residents and families spoke positively about the care provided and how much they like the environment.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service provider'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, staff, an external palliative care nurse and a general practitioner.

This audit has resulted in four identified areas of improvements, all of which relate to various aspects of quality and risk management. There were no corrective actions raised at the last audit to follow up on.

Consumer rights

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.

There is open communication between staff, residents and families, especially following adverse events. Local interpreter services are able to be accessed if required.

Information about how to make a complaint is readily available and a complaints register is maintained.

Organisational management

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.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monthly monitoring reports are provided to the board of the charitable trust. An experienced and suitably qualified person manages the facility.

The quality and risk management system is well described and includes collection of related information. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. A documented risk management plan is available and a health and safety system is being implemented. Policies and procedures support service delivery and are current and reviewed regularly.

Recruitment and orientation processes for new staff are based on current good practice. An education schedule identifies appropriate training opportunities that support safe service delivery and this is being carried through accordingly. Individual staff performance reviews occur annually.

Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

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.		Standards applicable to this service fully attained.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

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.		Standards applicable to this service fully attained.

There is a current building warrant of fitness. Electrical equipment is tested as required and bio-medical equipment checked and calibrated annually. External areas provide an accessible and safe environment.

Restraint minimisation and safe practice

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 implemented policies and procedures that support the minimisation of restraint. One enabler and two restraints were in use at the time of audit. Use of enablers is voluntary for the safety of residents. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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.		Standards applicable to this service fully attained.

The infection prevention and control programme aims to prevent and manage infections. Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	0	1	0	0
Criteria	0	35	0	3	1	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy, procedures and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission. Residents and family members interviewed were aware of their right to make a complaint and how to do this. Complaint forms are available near the reception area at the front entrance. The complaint register reviewed showed that no complaints have been received by the facility manager over the past year. The facility manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. One Health and Disability Commission complaint lodged in 2019 has been closed with a letter confirming actions taken by the service provider had been appropriate. Another health and disability complaint and one from the advocacy service have been presented to the facility manager this year and both of these are still open. Copies of documentation compiled to respond to these separate complaints were reviewed and confirmed the facility manager's cooperation with the requests. The facility manager is currently awaiting responses from the respective authorities.
Standard 1.1.9: Communication	FA	Open communication processes between the managers, registered nurses, residents and family members are in place. Any incident, accident or change in health status is reportedly conveyed to the person and to family as

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		soon as possible. Residents and family members stated they were kept well informed in such circumstances and were advised in a timely manner. This was evident in residents' records reviewed. Staff have received related training in March 2021. Those interviewed were aware of the principles of open disclosure, which are supported by policies and procedures that meet the requirements of the Code. There has been no requirement for use of an interpreter since the last audit. Similarly, there has been no requirement for additional services for residents with visual and or hearing impairments. An interpreter policy and procedure lists a range of services from which interpreter services may be accessed, including the local Wairau hospital.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Bethsaida Retirement Village is owned and operated by the Bethsaida Charitable Trust. A business plan valid until 2022 is reviewed each year and includes the vision, mission and core values of the service. Values include empathy, high quality care, professionalism, safety and security and knowledge and skills. Strengths, Weaknesses, Opportunities and Threats (SWOT) are regularly reviewed and the resulting information contributes to business objectives and goals. A board member of the Trust was briefly interviewed during the audit and informed the facility manager provides the board with adequate information and keeps them updated on any emergent risks. The facility manager confirmed attendance at the Trust board meetings on the fourth Wednesday of each month when a written and verbal report is provided. These reports include a health and safety review and updates on occupancy, any staff issues, accidents and incidents, infection incidence, complaints and any essential notifications made. The facility manager holds nursing and management qualifications, has had previous relevant experience and has been in the role for more than eight years. Responsibilities and accountabilities are defined in a position description and an individual employment agreement. Ongoing professional development is being maintained as are ongoing links with the sector through attending in-house education, conferences and regional DHB meetings with the portfolio manage present and by participating in local nursing leadership groups. Bethsaida Retirement Village holds contracts with the Nelson-Marlborough district health board to provide rest home and hospital services under the Aged Related Residential Care Agreement. At the time of audit, there were thirty seven residents receiving rest home level care, 13 hospital level and one person receiving respite rest home care. Prospective residents have already been allocated to the six beds not currently occupied. All beds are dual purpose, for the provision of either rest home or hospital level care.
Standard 1.2.3: Quality And Risk Management	PA	The organisation's policies and procedures describe a quality and risk system that reflects the principles of continuous quality improvement. This includes monitoring, management and review of adverse events,

Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	Moderate	infections, concerns/complaints, internal audit activities, health and safety, clinical services, food services, staffing, training, equipment and maintenance and resident and family feedback. A quality consultant provides support and advice on request for implementation of the quality and risk management system, in consultation with the managers develops service specific policy manuals and provides electronic platforms for the management of adverse events and infection surveillance. Some clinical services such as infection control, restraint and adverse events are being monitored and evaluated and some internal audits are being completed. A residents' survey was undertaken in February 2021; however no formal analysis of the feedback has been completed. There were examples of corrective actions being developed and these were effective for adverse event management but there were inconsistencies in the follow-up of these in other areas of the quality and risk management system. Registered nurse and staff meeting minutes confirmed aspects of service delivery are being analysed and reviewed. However, three monthly quality and risk meetings have ceased, reviews of the organisation's wider quality and risk system are no longer occurring, not all aspects of service delivery are being evaluated for quality improvement purposes, there are inconsistences in the follow-up of corrective actions developed, the internal audit schedule and feedback surveys is not being fully implemented and an organisational risk register is not available. These factors have been raised for corrective action against the relevant criteria. Staff reported their involvement in quality and risk management activities through meeting attendance, participating in training and complying with requests from registered nurses. The sample of policies reviewed as part of this surveillance audit cover all necessary aspects of the service and contractual requirements. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The clinical nurse manager has some familiarity with the Health and Safety at Work Act (2015) and assists with implementation of its requirements. In an effort to further improve clinical aspects of service delivery the clinical nurse manager has recently allocated the registered nurses with key responsibilities as coordinators. Examples of these include for health and safety, infection control, falls prevention, continence, pain and weight management, wound and skin care, restraint and staff training. Details have yet to be established.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and	FA	Staff report adverse and near miss events to a registered nurse who enters the information into a dedicated electronic portal. There was evidence of consistently completed recordings of events January to May 2021. Graphs that reflected variances in circumstances had been developed. The clinical nurse manager had analysed the information month by month and developed comprehensive and informative reports that included recommendations and corrective actions for follow-up. Individual incidents were also investigated with action plans/interventions developed and actions followed-up in a timely manner. Examples of follow-up included

reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		increased monitoring to prevent falls and/or skin tears and staff training such as for manual handling to reduce the incidence of skin tears. Adverse event data is collated, analysed and reported to registered nurse and staff meetings. The facility manager and the clinical nurse manager described how they work together to ensure essential notifications are completed on the relevant form when required. Documentation related to two service related Section 31 notifications plus one for the change of clinical manager that have been made since the last audit were viewed.
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	Human resources management policies and processes are developed in consultation with the quality consultant. Those reviewed are based on current good employment practice and relevant legislation. The recruitment process may or may not be in response to an advertised position; however, all applicants for employment are required to complete an initial application and have an entry interview with the relevant manager. Referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required are then undertaken. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. During interview, staff reported that the orientation process is adapted to suit the needs of the person, includes completion of a checklist and that time spent with a buddy may depend on previous work experience. Records in staff files show documentation of completed orientation requirements. A continuing education schedule is developed each year. The 2020 version includes a diverse range of topics of interest as well as mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Two staff members are internal assessors for the programme and they described how they also manage the overall staff education programme. All except one of the registered nurses are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training, or their name is highlighted and the staff person is scheduled onto the next training slot. Staff undertake an annual performance appraisal with the relevant manager and records of these were sighted.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and	FA	Documented policies and procedures include information for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The clinical nurse manager has developed an allocation book which designates the two wings each staff person will work on, when lunch breaks will be taken and who will do the medicine round, for example. The facility adjusts staffing levels to meet the

safe service from suitably qualified/skilled and/or experienced service providers.		changing needs of residents and registered nurses can request a staff person to extend their hours or call on an additional staff person when this is indicated. Residents and family interviewed were mostly satisfied with staff availability. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. There were very few absences recorded and staff spoke of working well as a team. The facility manager responds to after-hours enquiries related to management issues and the clinical nurse manager, or clinical care coordinator, is available for clinical enquiries. With all registered nurses and senior healthcare assistants having a current first aid certificate, there is always at least one person on duty who is first aid certificated. Two registered nurses are consistently rostered on both morning and afternoon shifts and one on the night shift. These are in addition to the clinical nurse manager and the clinical care coordinator who primarily work Monday to Friday morning shifts. Registered nurses and healthcare assistants informed there are adequate staff members on duty to undertake the allocated duties and there is always sufficient information and support available when necessary.
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	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Staff were reminded about always following policies and procedures for delivery of medication management. All staff, including registered nurses who administer medicines are competent to perform the function they manage. All RNs are syringe driver competent. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly, monthly and on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. All requirements for pro re nata (PRN) medicines were met. The required three-monthly GP review is consistently recorded on the electronic medicine chart. There were no residents self-administering medications at the time of audit. Appropriate processes are in place to manage this in a safe manner if required.

		There is an implemented process for comprehensive analysis of any medication errors.
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 food service is provided on site by a qualified chef and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (20 May 2021). No recommendations were made at that time. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Marlborough District Council current until 23 March 2022. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. The kitchen works together with the DT to provide meals for theme days and special events. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. Observations included viewing multiple examples of actions taken by the caregivers that demonstrated they were very familiar with the needs of the individual residents. Staff listened to requests from residents and ensured their safety when mobilising them or assisting them in some way. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high level. Care staff confirmed that care was provided as outlined in the documentation. In most instances they use handover to ensure they have the latest information and will ask a registered nurse if they are uncertain about anything. An interview with the aged residential care hospice nurse confirmed that they are contacted in a timely manner of residents as they reach the stage of palliative care and that they provide support to residents, family members and staff. They had no concerns about the standard of care of care provided. A range of equipment and resources was available, all of which was 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 activities programme is provided by a diversional therapist (DT) and activity coordinator. A volunteer chaplain visits regularly to provide holistic care and one to one support to residents. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help develop both individual and group activities programmes that are meaningful to the residents. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Competitions are held with other local rest homes. All residents have a calendar in their rooms and an announcement is made over the intercom. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme meets their needs.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse (RN). A detailed care plan evaluation occurs every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, wounds, continence and general health. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for	FA	A current building warrant of fitness with an expiry date of 1 July 2021 is publicly displayed. No alterations or modifications have been made to the building since the last audit.

their purpose.		
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	Infection surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal and the upper and lower respiratory tract. All confirmed infections are documented into the electronic incident reporting system and become a component of the incident log. The infection prevention and control coordinator reviews all reported infections and any required management plans are discussed at handover, to ensure appropriate treatment is instituted. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Graphs are produced that identify trends for the current year, and comparisons against previous years. Results of the surveillance programme are shared at registered nurse meetings and regular staff meetings. It is a meeting agenda item for quality and risk management meetings. Data is benchmarked externally with other aged care providers and the results provide assurance that infection rates in the facility are average for the sector.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical nurse manager is the restraint coordinator and has been in the role for just over a year. As per the role description, the restraint coordinator provides support and oversight for enabler and restraint management in the facility. On the day of audit, bedrails were in use as a restraint for one resident and a reclining cloud chair for another. A resident in hospital level care was voluntarily using bedrails as an enabler. All were of the least restrictive nature, were recorded in the restraint and enabler register and had been reviewed within the past six months. A similar process is followed for the use of enablers as is used for restraints. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff. Staff undertake restraint training every two years and complete an annual restraint competency.

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 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.	PA Moderate	A comprehensive quality and risk management system that uses a Plan, Do, Study, Act framework is described within the organisational policy and procedure manual. A series of staff meetings, including three monthly quality and risk committee meetings were regularly occurring. Recorded minutes of meetings of health care assistants, registered nurses and auxiliary staff were viewed; however, the last quality and risk meeting minutes were dated in March 2020. There was limited evidence that monitoring of the key elements of the quality and risk system had been re-instated following the COVID-19 lockdown. It was also evident during interview that the current quality and risk co-ordinator requires additional mentoring and support to undertake the role competently.	Quality and risk management meetings/review processes have not all been re-established since March 2020; therefore, the documented quality and risk management system is not currently being implemented in a coordinated manner.	The quality and risk management system is reinstated as per the description in the organisation’s policies and procedures. 90 days

Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	Key components of service delivery, including incidents, complaints, infection control, health and safety and restraint minimisation are being intermittently discussed and reported through meetings such as registered nurse and health care assistant meetings. This is not occurring as described within the organisation's policies and procedures or the quality and risk plan. In the absence of a functioning quality and risk management system, there is also limited evidence to demonstrate these key components of service delivery are being monitored for quality improvement purposes and to ensure the safety of residents.	In the absence of a coordinated quality and risk management system, some key components of service delivery are not being linked into an organisational quality and risk management system.	Monitoring and review of key components of service delivery, including incidents, complaints, infection control, health and safety and restraint minimisation are reported through the quality and risk management system to enable ongoing quality improvement processes to be maintained. 180 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	The quality and risk management system requires monitoring and review of adverse events, infection rates, concerns/complaints, internal audits, food services, staffing, training, equipment and maintenance. There is oversight of some aspects of the quality system including the review of incidents, accidents and adverse events. However, with a breakdown in quality reviews of the quality and risk management system, there are multiple gaps. For example, quality improvement processes are not evident, internal audits	Reviews of the overall quality and risk management system have not occurred as per the policy. Quality review systems such	Processes that enable measurement of achievement against the quality and risk management plan require reinstatement.

		are not consistently occurring as per the schedule and although corrective actions are being developed for some identified shortcomings, it was not always possible to see how or if these had been followed up and closed. The word 'ongoing' is noted against both corrective actions and required improvements in meeting minutes, with no definitive directions. Residents' survey feedback has not been formally analysed for quality improvement purposes.	as internal audits and resident/family surveys are not always occurring in a manner that contributes to quality improvement.	180 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Low	Risk identification and risk management processes are described in the organisation's risk management policies and plan. Severity assessment codes are in use for reviews of adverse events. There is an updated hazard register and the risk management plan states risks are assessed under the headings of safety management, security management, hazardous materials, emergency preparedness and equipment management. Presently, there is no organisational risk register to assist with risk management throughout the organisation's operations. The ability to meet this standard is further compromised because the overall quality and risk management system of the organisation is not currently functional.	An organisational risk register is not available; therefore, not all actual and potential risks are being identified, monitored, analysed, evaluated and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk.	An organisational risk register that identifies risks to be monitored, analysed, evaluated, and reviewed according to severity of the risk and the probability of change in the status of that risk requires development. 180 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.