Sunrise Healthcare Limited - West Harbour Gardens

Introduction

This report records the results of a Certification 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 BSI Group New Zealand Ltd, 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:	Sunrise Healthcare Limited
Premises audited:	West Harbour Gardens
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 16 June 2021 End date: 17 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: 71

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

West Harbour Gardens rest home and hospital is one of three facilities owned by Sunrise Healthcare. The facility provides rest home, dementia, and hospital level of care for up to 74 residents including younger people with disabilities. On the day of the audit there were 71 residents.

A facility manager is responsible for the daily operations of the service and they are supported by a clinical manager.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff, and the general practitioner.

This certification audit identified areas for improvement around the following: advocacy services, the quality improvement programme, orientation programme, staffing, an integrated file for each resident, interventions described in care plans, the activities programme, dating of eye ointments, safety for residents who smoke, and cleanliness of the facility.

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.		Some standards applicable to this service partially attained and of low risk.

Policies and procedures adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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.

Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager (non-clinical) and clinical manager are responsible for day-to-day operations. The clinical manager is supported by a clinical coordinator. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is established. Data collected is collected and analysed.

Residents receive appropriate services from suitably qualified staff. Staff sign an employment agreement and job description prior to commencing employment. An orientation programme is established. The education and training plan includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week.

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

There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and plans residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed in resident records are reviewed at least six-monthly. Resident files included medical notes by the contracted GP and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and some senior caregivers are responsible for the administration of medicines and complete annual education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three-monthly.

A diversional therapist oversees the activity team and coordinates the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and preferences for each resident group. Residents and families reported satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Resident bedrooms are personalised with access to communal facilities. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. There is at least one staff member on duty at all times with a current first aid certificate.

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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. A restraint register is maintained. During the audit three residents were using a restraint and six residents were using enablers.

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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical manager) is responsible for coordinating education and training for staff. The infection control coordinator has completed online training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	40	0	4	6	0	0
Criteria	0	90	0	5	6	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	West Harbour Gardens Residential Care policies and procedures are mostly being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) (link 1.1.11.1). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the in-service programme (link 1.2.7.5). Interviews with staff (five caregivers, five registered nurses (RNs), and one clinical coordinator, one diversional therapist, one cook, one laundry, one cleaner, one maintenance staff) and managers (facility manager, general manager (director) and one clinical manager) confirmed their understanding of the Code.
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	There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in nine of nine resident files reviewed (three rest home, four hospital and two dementia). Resuscitation status and advance directives were appropriately signed. Medically indicated not for resuscitation status (as applicable) were in place for residents deemed unable to make an informed choice. Copies of the enduring power of attorney (EPOA) were present and activated as required. An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed

		choices and informed decisions. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. All resident's files reviewed had signed admission agreements on file.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	PA Low	Residents interviewed confirmed they are aware of their right to access someone to help them to process a complaint, however they were not sure of the independent advocacy services available to them. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on residents' family/whānau and chosen social networks.
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 and relatives interviewed confirmed open visiting. The service is responsive to young people with disabilities accessing the community, resources, facilities, and mainstream supports such as education, public transport, and primary health services in the community. The activities programme includes opportunities to attend events outside of the facility. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint register that includes complaints received, dates and actions taken. The facility manager or clinical manager signs off each complaint when it is closed. There is evidence of lodged complaints being discussed in the staff meetings. Twelve complaints were received in 2020 and seven have been received in 2021 to date. Four internal complaints were reviewed, and all were responded to in timeframes as per the Code and the service policies. The DHB requested follow up against aspects of three complaints (one lodged with the Health and Disability Commission and two lodged with the DHB). The audit did not substantiate issues

		identified around GP hours, timeliness of service delivery, or laundry services. The audit did substantiate issues identified around orientation of staff (link 1.2.7.4), staffing issues (link 1.2.8.1), cleanliness (link 1.4.6.2), and physiotherapy services.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is an information pack given to prospective residents and families that includes information about the Code. There is the opportunity to discuss aspects of the Code during the admission process. Ten residents including three residents requiring rest home level of care and seven residents requiring hospital level of care (including one under a long--term service – chronic health conditions (LTS-CHC) contract, one ACC funded, and one young person with a disability [YPD]) were interviewed. Five family members (one with family at rest home level of care, two with family in the dementia unit, and two requiring hospital care) were interviewed. They all confirmed that information had been provided to them around the Code. Large print posters of the Code are displayed throughout the facility. Managers stated that the clinical manager or RN discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
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	A tour of the premises confirmed there are areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Young people with disabilities are able to maintain their personal, gender, cultural, religious, and spiritual identity, evidenced in all three files reviewed of residents who were young persons with a disability (one intellectual disability, one physical disability, one long-term chronic condition). Care staff interviewed could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect (link 1.1.4.1). Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered in most cases noting that three of the 10 residents had concerns around most areas of the service. Interviews with caregivers described how choice is incorporated into resident cares.

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	The Māori health plan policy for the organisation references local Māori health care providers and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. During the audit there were no residents who identified as Māori living at the facility.
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	Individual beliefs or values are discussed and incorporated into the care plan, evidenced in nine care plans reviewed. Six monthly care plan reviews assess if needs are being met. Family is invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs. YPD are seen as having their own culture and cultural needs and preferences. The service caters for this group of residents through focused activities, and encouragement around maintaining independence. Residents who identified as young people stated that they were able to come and go as they pleased with activities available if they wished to participate.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The managers and RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respect them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregiver role and responsibilities. Professional boundaries are reconfirmed through education and training sessions and staff meetings, and the facility manager stated that there would be performance management if there was an infringement from a staff member. Caregivers are trained to provide a supportive relationship based on sense of trust, security, and self-esteem. Interviews with care staff confirmed that they understood how to build a supportive relationship with each resident.
Standard 1.1.8: Good Practice Consumers receive services of an	FA	The service promotes evidence-based practice and encourages good practice. Policies and procedures are aligned with current accepted best practice. The content of policy and procedures

appropriate standard.		are sufficiently detailed to allow effective implementation by staff. Registered nursing staff are on site 24 hours a day. A house GP visits the facility two days a week. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed confirmed that they were satisfied with the care provided for all residents. The service receives support from the district health board, which includes visits from the mental health team and nurse specialist visits. Physiotherapy services are provided on site two and a half hours per week by an employed physiotherapist with a contracted physiotherapist also providing at least another three hours monthly. There is a physiotherapist assistant who works five days a week to support residents to keep active and to complete tasks expected to be identified by the physiotherapist. All new residents are assessed by the physiotherapist. Transfer plans are developed and posted in each resident's room. The service has links with the local community and encourages residents to remain independent. Activities staff lead group activities and also provide one-on-one visits with residents, in particular the younger residents. Young persons are encouraged and supported to remain active in their communities. Adverse event data is collected and collated. Action plans are implemented to minimise risk and processes are reviewed and evaluated.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 21 adverse events reviewed indicated that family are kept informed. Family members interviewed confirmed they are notified following a change of health status of their family member. Monthly family/resident meetings provide a venue where issues can be addressed. An interpreter service is available and accessible if required. Families and staff are utilised in the first instance. A range of communication methods are available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the	FA	West Harbour Gardens provides care for up to 74 residents. This is one of four aged care facilities owned and managed by Sunrise Healthcare. The service is certified to provide hospital (medical, geriatric), dementia, and rest home level care. The service is also certified to provide care for residents identified as under the following levels of care: residential disability services – intellectual and physical. All resident rooms apart from those in the dementia unit are dual-

needs of consumers.		purpose. On the day of the audit, there were 71 residents. This included 18 residents at rest home level of care (including one long term service – chronic health conditions [LTS-CHC]), 42 residents requiring hospital level care (two using respite services, one ACC funded, 12 YPD, three LTS-CHC), and 11 in the dementia unit (noting that this is an 11-bed unit). One resident is under a mental health contract (hospital level of care). A 2021 business plan is documented for the service. The quality and risk management plan identifies a vision, mission, and objectives with anticipated outcomes. Business goals and quality/risk objectives are reviewed quarterly as evidenced. The facility manager (non-clinical) has been in the role for the past five weeks. He completed one week of orientation with the owners of the facility. He is supported by a full-time clinical manager/RN and a clinical coordinator/RN. He has previous experience in various management roles both in the public and private sectors and has a Bachelor of Commerce. On interview it was confirmed that the facility manager clearly understands his role and his boundaries as a non-clinical facility manager. He refers all clinical matters to the clinical manager. The clinical manager is a registered nurse who has worked in aged care for three years and has been employed at West Harbour Gardens for 16 months. He has been in his role as a clinical manager for the past eight months. The clinical manager has maintained a minimum of eight hours of professional development relating to his role. The owners and facility manager are aware of the facility manager's professional development obligations in relation to the aged residential care contract with the DHB. Section 31 reports were completed to inform the Ministry of Health of the facility and clinical managers appointments.
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 owners/directors are responsible for operational management in the absence of the facility manager. A clinical coordinator/RN covers all clinical responsibilities in the absence of the clinical manager. The clinical coordinator has 18 months experience in aged care and has been in the position since March 2021.
Standard 1.2.3: Quality And Risk	PA	A quality and risk management system is established with gaps identified around communicating results to staff and providing evidence to support the implementation of corrective actions. The

Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	Moderate	service has policies and procedures and associated implementation systems, adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies were last reviewed in May 2020. Work remains underway to update policies that were implemented prior to the purchase of the facility. Young people with disabilities have input into quality improvements to the service with examples provided. Satisfaction with choices, decision making, access to technology, aids equipment and services contribute to quality data collected by the service. Resident and family meetings are held each month, led by activities staff. Minutes are maintained and there is evidence to indicate that residents' issues that are brought forth are addressed. Annual resident satisfaction surveys were last completed in 2020 with plans to complete another survey in the near future. The 2020 survey results have been collated. Areas for improvement were highlighted in the 2020 results but there was no evidence to indicate that these corrective actions were implemented. The internal audit programme is designed to monitor compliance. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to RNs in the clinical meetings, but data tabled for discussion was missing in staff meetings. Internal audit results indicated high compliance with no indication of corrective actions. Health and safety policies are implemented and monitored by a health and safety committee. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. One serious staff injury that occurred in May 2021 resulted in this being reported to Work Safe during the audit. Falls prevention strategies are in place including sensor mats, and intentional rounding. A physiotherapist is on the falls committee along with the clinical manager, RN, two caregivers and one housekeeper. Strategies implemented to reduce falls include regular toileting, intentional rounding, sensor mats, and ensuring calls bells are always accessible to the residents.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected	FA	There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. They are signed off by the clinical manager when complete.

consumers and where appropriate their family/whānau of choice in an open manner.		A review of 21 accident/incident forms identified that forms are fully completed and include follow-up by a registered nurse. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are recorded for any suspected injury to the head or for an unwitnessed fall (a review of six unwitnessed falls confirmed that this occurred as per policy). The clinical manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents, and unexpected death. There was evidence of three Section 31 reports completed over the past year (new facility manager and clinical manager, one pressure injury, one police investigation for a resident who absconded).
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	Human resources policies cover recruitment, selection, orientation and staff training and development. Eight staff files reviewed (two RNs, four caregivers, two kitchen assistants) included a recruitment process (interview process, reference checking, police check) signed employment contracts, and signed job descriptions. A register of registered nursing staff and other health practitioner practising certificates is maintained. An orientation programme is established to provide new staff with relevant information for safe work practice but is lacking documented evidence of this being completed. There is an implemented annual education and training plan. The education focused on young people with either ID or PD as part of the scenarios and training. Training is completed either via in-services, tool box talks and online. There is a staff register for each training session that indicates staff have completed a minimum of eight hours of education per annum. Performance appraisals were up-to date in all staff files reviewed of staff who had been employed for one year or longer. Registered nurses are supported to maintain their professional competency. Five of nine registered nurses have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication, syringe driver, wound and insulin competencies. Seven caregivers work in the dementia wing. Six have completed their dementia qualification and the remaining staff has been working in the dementia unit for less than 18 months and are enrolled in the dementia Careerforce programme.
Standard 1.2.8: Service Provider Availability	PA Moderate	A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The facility manager and clinical manager/RN are rostered five

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		days a week (Monday – Friday) and are supported by a clinical coordinator/RN who is rostered Tuesday – Saturday. The clinical manager and clinical coordinator share on-call responsibilities. The dementia wing (Manuka) (11 residents) is overseen by the clinical coordinator (Tuesday – Saturday) and a senior caregiver on Sundays. Two caregivers cover the AM shift (long shifts), and two caregivers cover the PM shifts (long shifts). Nights are staffed with one caregiver. There are three remaining wings (Rata, Kowhai and Ngaio). The highest level of care is in Kowhai with 22 hospital level (including seven YPD) and two rest home level residents. Kowhai is staffed with one RN on the AM and PM shifts. Four caregivers (two long shifts and two short shifts (0700-1300) cover the AM shifts and three caregivers (two long shifts and one short shift (1500-2100) cover the PM shift. Rata (12 hospital including two YPD, and 12 rest home) and Ngaio (8 hospital including three YPD, and 4 rest home) is staffed with one RN on the AM and PM shifts. Three caregivers (two long shift and one short shift (0700-1300)) cover the AM shift, the PM shift is covered with two caregivers (one long shift and one short shift (1500 - 2100). The night shift for these three wings is staffed with one RN and three caregivers (one for each wing). As per interview with the facility manager and clinical manager, staffing shortages are the result of the inability to cover staff absences (e.g., staff either giving late notice or are not showing up for work). Agency staffing is not being utilised. The facility manager also reported that five new staff have been employed in the past month (one kitchen assistant, one housekeeper and four caregivers). A selection of staff, residents and families interviewed indicated that staffing levels are not adequate. This is known to the facility manager and is being addressed.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Moderate	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse, including designation. Information is recorded electronically on a patient management system with other information documented in hard copy in a variety of places. Archived residents' files are stored securely. Electronic information is backed up using cloud-based technology. All computers are individually password protected. Each resident does not have an integrated file.

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	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs are provided for families and residents prior to admission. Admission agreements of long-term residents were reviewed and align with all contractual requirements. The respite care residents had signed a short-stay agreement. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	The service has an electronic medication administration system. Two medication rooms were checked at the audit. There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses have been assessed for medication competency on an annual basis. Caregivers' complete competency assessments for the checking of medications. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. The service uses robotic rolls, and these are checked on delivery against the medication charts. Standing orders are not used. Vaccines are not stored on site. There are no residents who self-administer medication. The medication fridge is monitored daily with temperatures within normal range. Stock drugs are checked monthly with an impress list in place. All medications are stored safely. Eye drops were not always dated on opening. All 18 medication charts reviewed (four rest home and ten hospital level of care, and four dementia unit) met legislative prescribing requirements. The GP has reviewed the medication charts three monthly. All medications had been administered as prescribed.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this	FA	All meals and baking are prepared and cooked on site by a qualified cook, who is supported by morning and afternoon kitchenhands. There is a four-weekly menu which has been reviewed by a dietitian September 2019. The main kitchen is adjacent to the main dining room and meals are served from the bain marie directly to the residents in the dining room. Meals are plated and covered with insulated lids and delivered to the smaller dining room. Dietary needs are known

service is a component of service delivery.		with individual likes and dislikes accommodated. Dietary requirements (diabetic desserts and lactose free diets), cultural and religious food preferences are met. Additional or modified foods are also provided by the service. Staff were observed assisting residents with their meals and drinks. Fridge, chiller, and freezer temperatures are taken and recorded daily with all temperatures reviewed in normal range. End-cooked food temperatures are recorded. Inward chilled goods have temperatures checked on delivery. Cleaning schedules are maintained. Chemicals are stored safely. Kitchen staff were observed to be wearing correct personal protective clothing. The food control plan expires on the 1 November 2021. Food services staff have completed training in food safety and hygiene. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. Snacks are available 24-hours a day with food kept in the dementia unit should this be required. Of the ten residents and five family members interviewed, four residents and two family members interviewed stated that the food was 'terrible'. All others praised the food and were observed to enjoy the food on the day of audit. The issues around the food service have already been identified in a satisfaction survey (link 1.2.3.8).
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	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment on admission including applicable risk assessment tools such as falls and pressure injury risk assessments. Initial interRAI assessments had been completed for all residents except for those using respite care or identified as under a CHS-CHC contract. Resident needs and supports were identified through the ongoing assessment process in consultation with significant others. The long-term care plans in place reflect the outcome of the assessments.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Resident care plans reviewed (electronic), identified support needs as assessed and included resident goals. However, interventions were not always fully documented for all assessed needs. Care plans evidenced resident (as appropriate) and family involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files do not all demonstrate service integration (link 1.2.9.10). There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian. The care plans for the younger persons reflected the resident's individual physical and emotional supports required to maintain their wellbeing. There was evidence of allied health professional involvement in the resident's care such as physiotherapist, dietitian, community teams and ACC engagement. An initial assessment and initial care plan had been completed for the respite care resident and for a resident under LTS-CHC funding.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required, GP, dietitian, or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the progress notes of the resident electronic file. Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds. There were 13 skin tears, four venous ulcers, three wounds, one scratch, two fungal infections, one graze, two blisters, two pressure injuries (one stage one and one stage two), one ulceration due to cellulitis and one nail that had partially come off. There is a range of pressure injury prevention equipment readily available and in use. All residents had an assessment for risk of pressure injuries on admission and at six monthly intervals. The two hourly turns were sighted as being completed for residents who required this. There are residents of higher acuity such as paraplegic and some reported to be non-compliant with PI interventions. Chronic wounds have been linked to the long-term care plan. There was evidence of wound nurse specialist involvement in the management of wounds. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional

		requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, pain, restraint, and challenging behaviour. Acute care needs (on the electronic resident system) document appropriate interventions to manage short-term changes in health. Interventions were not always well detailed in each resident file reviewed (link 1.3.5.2).
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.	PA Low	The service has a qualified registered diversional therapist (DT) who provides the activity programme. She works 75 hours a fortnight and has been at the service for three years with two and a half years' experience at a different service. The DT was on leave during the audit and no cover had been organised for her. The DT provides individual and group activities in all areas of the rest home and hospital to meet the recreational preferences of the resident groups. The programme includes news group, exercises, walking groups, ball therapy, board games, arts and crafts, sensory activities, word games, cooking, knitting club and walking groups. Community visitors include churches, inter-home visits, pet therapy, entertainers, haka groups. There are weekly outings in the van. The van drivers and activity team hold current first aid certificates. Residents enjoy scenic drives to the beaches and outings to community cafes, RSA and other rest homes for games and competitions. One-on-one activities such as individual walks, massage, reading, and pampering occur for residents who are unable, or choose not to be involved in group activities. Activities provided are appropriate to the needs, age, and culture of the residents. The younger people are invited to attend the group activities of their interest. The activity team make daily contact with the younger people and ensure they have their recreational needs met. They have good family support and go out regularly with family or their support persons to community events and activities. The DT drew up an activity plan for the young residents, but they did not want to engage in it and stated that they preferred to go out themselves or with friends. This was confirmed by the young residents interviewed. There is a separate programme for residents in the dementia unit noting that this is mostly implemented by care staff. The programme includes walks, outings, mixing with activities in the rest home area wen ever possible and as per resident abilities. An activity assessment and plan are completed on admission in consultation with the resident/family (as appropriate). Attendance records are kept. While goals were documented for each resident around activities, the plans did not include interventions. Twenty-four-hour activity

		plans were not developed for residents in the dementia unit. Families are invited to the resident meetings. The service also receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families. Residents interviewed were happy with the activities offered. The younger persons were happy with the activities they could access.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans reviewed were evaluated by the RN within three weeks of admission and long-term care plans developed. The resident and/or relative and relative health professionals are involved in the evaluation process. Long-term care plans are evaluated six-monthly. The GP reviews residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes and acute care needs forms. The paper-based evaluations involved members of the multidisciplinary team and residents/relatives.
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 disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
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.	PA Moderate	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas and safety datasheets are available. Relevant staff have completed chemical safety training. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. There is a designated smoking area, however there are issues relating to smoking for residents and others.
Standard 1.4.2: Facility Specifications Consumers are provided with an	FA	The building has a current building warrant of fitness that expires 16 November 2021. One owner/director is the maintenance staff with contractors brought in for specific issues.

appropriate, accessible physical environment and facilities that are fit for their purpose.		Essential contractors are available 24 hours. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment is completed by an external contractor with this last completed in May 2021. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Temperature recordings reviewed were below 45 degrees Celsius. Rooms are refurbished as they become vacant. The facility has sufficient equipment to allow personal, rather than communal use and includes items such as walkers, wheelchairs, and hoist slings. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The dementia unit is secure. There is safe access to the outdoor areas. Seating and shade are provided with a separate secure outdoor area for residents in the dementia unit. The dementia unit outdoor area has a number of entry points and a circular path with established plants. All external areas and decked areas are well maintained. The care staff including RNs interviewed, stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
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	Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are adequate numbers of communal bathrooms/toilets in each wing. Privacy is assured with the use of ensuites, and communal toilet facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning.
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	All rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Bedrooms have external doors that open out onto the courtyards or outdoor areas. Residents and families are encouraged to personalise their rooms. This was evident on audit days.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining	FA	Communal areas within the facility include a large main dining room where most activities take place. There are private lounges in each wing with a computer and skype available in one of the

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		lounges. Seating and space are arranged to allow both individual and group activities to occur. All furniture is safe and suitable for the residents. Space and privacy are afforded to younger disabled persons within the service within these communal areas. A younger person interviewed during the audit stated that they had made friends with others in the service with similar likes and they enjoyed being in wings together. The dining areas are homely, inviting, and appropriate for the needs of the residents. Seating and space are arranged to allow both individual and group activities to occur. All furniture is safe and suitable for the residents.
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.	PA Low	Laundry staff are rostered on seven days a week. There are two dryers and two washing machines with a clear separation of dirty and clean areas. The resident list also identified laundry that is tagged with the resident's name etc. Residents interviewed around laundry services were overall happy with the service. There are cleaners on duty each day. Cleaning trolleys are well equipped with cleaning materials and colour coded equipment. Cleaning trolleys are kept in locked areas when not in use. The service conducts regular reviews and internal audits of cleaning services to ensure these are safe and effective. All personal clothing and linen are laundered on site. There is a dirty and clean area designated in the laundry area and there was adequate clean linen available on the day of audit. Residents and family interviewed, reported satisfaction with the laundry service. There were issues identified through observation and as reported through resident and family interviewed around cleaning. Residents and family reported that there had been an issue with pests. Maintenance staff stated that pest control had addressed issues raised and there was continued monitoring and management of any pests as these were identified. Pest control services were contracted to attend the site monthly with this confirmed as being provided. They acknowledged that there had been issues, particularly in summer.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency and disaster policies and procedures to guide staff. The emergency plan considers the special needs of young people with disabilities in an emergency. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months with the last having taken place in February 2021. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting is in place which is regularly tested. A civil defence kit is in place. Supplies of stored water and food are held on site and are adequate for three days. Electronic call bells were evident in resident's rooms, lounge areas, and toilets/bathrooms noting that there were issues with weak call bell sounds in the dementia unit on the day of audit and this

		was addressed. The facility is kept locked from dusk to dawn and night staff check to ensure that these remain locked overnight.
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	Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There are sufficient doors and external opening windows for ventilation.
Standard 3.1: Infection control management 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.	FA	The infection control coordinator (clinical manager) oversees infection control for the facility and is responsible for the collation of infection events. The infection control coordinator has a defined job description. Infection events are collated monthly and reported to the monthly clinical meeting that includes infection control (link 1.2.3.6). The 2020 infection control programme has been reviewed and is linked to the quality system. Infection quality goals are incorporated into the overall quality plan. The facility has a Covid/Pandemic plan in place and appropriate amounts of PPE on hand to last for at least two weeks in case of a further lockdown. During Covid the service held regular virtual meetings with the DHB Covid preparedness team to check policies, procedures, and service readiness. Staff and residents have commenced Covid vaccinations. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility and Covid scanning and/or manual sign in is mandatory. Residents are offered the annual influenza vaccine. There have been no outbreaks in the previous year.
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	There are adequate resources to implement the infection control programme at West Harbour Gardens. The infection control resource nurse liaises with the infection control committee who meet three monthly and as required (more frequently during Covid lockdown). Information is shared as part of the clinical (registered nurse) meetings. External resources and support are available through external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the infection control committee with external

		consultant oversight.
Standard 3.3: Policies and procedures 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.	FA	The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training, and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are reviewed regularly.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating education and ensuring staff complete the online training available on the 'care online' internet-based education system. Training on infection control is included in the orientation programme. Staff have completed online infection control study in the last 12 months with a large amount of training given in 2020 during the Covid-19 pandemic. The last training around infection control and Covid-19 was provided to staff in June 2021. The infection control coordinator has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.
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	Surveillance is an integral part of the infection control programme and is described in the facility's infection control manual. The infection control coordinator collates the information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed with the clinical meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Results from laboratory tests are available as required. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of	FA	Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers.

restraint is actively minimised.		There were three hospital level residents using restraints (two lap belts and one chest belt with wedge) and six hospital level residents who voluntarily requested the use of an enabler (five lap belts and one bedrail - hospital level). One resident file of a resident using an enabler was reviewed. The resident using the enabler gave written consent for the use of the bedrails to assist them to move in bed. The enabler was linked to the resident's care plan and was being reviewed monthly. Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.
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	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The clinical manager is the designated restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint (e.g., bed rails, lap belts, chest belt with wedge) for safety. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and/or family/whānau are evident. Two residents' files where restraints were in use were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family, and the GP. The use of restraint is linked to the resident's restraint care plan, sighted in both residents' files

		reviewed (link 1.2.9.10). An internal restraint audit monitors staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify monitoring was evidenced on the monitoring forms for the residents' files reviewed. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers. This register is updated monthly.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are completed every month, evidenced in one resident record where restraint was used and in one enabler file reviewed.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint minimisation programme is discussed and reviewed and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures, and reviewing the staff education and training programme.

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 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.	PA Low	Residents and family are expected to be informed of the nationwide advocacy services, however those interviewed were unsure or not able to describe nationwide advocacy services. Registered nurses stated that they informed residents and family around advocacy services. There were no pamphlets or posters on walls advertising the nationwide advocacy services.	Residents and family were not aware of nationwide advocacy services and information around these services was not available.	Provide education and information to residents and family around the nationwide advocacy services. 90 days
Criterion 1.2.3.6 Quality improvement data	PA Low	There are processes in place to review data that is collected from audits, adverse events etc, however	Data from internal audit reports and adverse events is not being reported at the monthly staff meetings.	Ensure that data collected from internal

are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.		this is not always being reported to staff through relevant staff meetings.		audit reports and adverse events is reported at the monthly staff meetings. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	Where corrective actions are identified, there is a lack of adequate evidence to indicate that they are addressed/resolved.	The 2020 resident/family survey indicated that corrective actions were required to address residents' issues. Corrective actions identified included providing residents with a session on the code of rights, raise awareness with residents around care plans, remind staff to wear name badges, and complete a food survey. There was a lack of evidence to indicate that these corrective actions had been implemented. Resident meetings also identified issues with no evidence to indicate that the issues identified were addressed and communicated to residents.	Ensure corrective actions identified reflect evidence of their implementation. 60 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Moderate	An orientation programme is established but documentation does not identify this is fully implemented. Missing is evidence to indicate that the orientation programme for staff is being completed. New caregiver applicants that have had no experience caregiving are requested to observe caregivers for two days as volunteers before applying for a caregiver role. If it is determined that the job is what they are interested in and the service thinks they will be a good fit then the individuals commence a five-day	Five of eight staff files selected for review were missing evidence of a completed orientation programme. The remaining three files did have evidence of undergoing orientation, but these were not completed in their entirety. Interviews with a selection of staff indicated that the orientation programme did not successfully prepare them for their job responsibilities.	Ensure all staff are provided with a suitable orientation programme with evidence to support that it is being completed. 60 days

		orientation programme.		
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	Staffing shortages, expressed by staff, residents and family are resulting from staff not working their rostered hours.	The facility manager reported that he is often unable to fill staff vacancies, that staff are calling in at short notice, or are just not showing up for work. Three weekend days were selected for review. One weekend day (12 June 2021) the AM was short one long and one short shift caregivers, the PM was short one (short) PM shift caregiver and the night was short one caregiver. The next weekend selected (5 June 2021) was short one night shift caregiver. The next weekend day selected (29 May 2021) was short one (long) shift caregiver on the AM shift, one (short) shift caregiver on the PM shift and one caregiver on the night shift. The facility manager confirmed that this is an ongoing issue. Interviews with residents, families and staff confirmed that many days staff are working with less than adequate (rostered) staff. Complaints regarding lengthy wait times when responding to call bells was also expressed by residents and families. Since the draft report the service has advised, when the current facility manager started in May, there were a number of staff vacancies to fill. In June staff attendance was not good. The facility manager and management team have been working on this issue. They have since hired 19 caregivers. Advised they continue to train staff and are managing their performance. Evidence identified recently, staff attendance has been really good. They have also arranged for the clinical manager to work from Tuesday to Saturday and nurse coordinator works from Sunday to Thursday to ensure weekend attendance improves. The facility manager has been working regular Sundays to manage staff	Staffing vacancies are required to be filled to ensure adequate staffing levels. 30 days
Criterion 1.2.9.10 All records pertaining to	PA Moderate	Resident files are not integrated. There is information around the resident written in a number of	Each resident does not have an integrated file.	Ensure that each resident has an

individual consumer service delivery are integrated.		places including additional information documented in the care plans, guidelines on the resident bedroom wall (not linking to or documented in care plans), physiotherapy assessments and interventions written in the resident's progress notes, a summary of the shift completed at the end of each shift with information not documented necessarily in progress notes or linked to the care plan, and restraint assessments and evaluations held separately to the resident's file. There was some confusion from staff interviewed at times when staff were describing cares to be provided to a specific resident. A behavioural monitoring form was kept for all residents in the dementia unit. This formed a summary of challenging behaviour for that shift. Again, there was a lack of an integrated record for each resident with a summary of all resident behaviour on one form. A wound register is kept in the nurse's station and medication files are kept separately in the medication room with the medicines. This is appropriate to the service being delivered.		integrated file. 90 days
Criterion 1.3.12.1 A medicines	PA Low	Eye drops and other medication that has a short shelf life when opened is expected to be dated on opening.	Five packets of eye drops had not been dated when opened.	Ensure that packets with eye drops or

management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		Not all eye drops had been dated when opened.		other medicine with a short shelf life are dated when opened. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Resident care plans reviewed (electronic), identified support needs as assessed and included resident goals. However, interventions were not always fully documented for all assessed needs.	Interventions were not always documented well in resident files reviewed. Examples are as follows: file one did not include interventions to prevent a pressure injury getting worse (ACC hospital). Catheter and bowel cares were not well documented (ACC hospital). . In file two, there were no interventions documented around management of seizures should they occur (the resident had a history in the past of seizures), and bowel management, while documented did not describe what to do if problems with bowel management emerged (ID YPD Hospital) File three did not include documentation around management hyper or hypo glycaemia (LTS-CHC RH). File four did not include clear guidelines around continence management or around shortness of breath (RH). While there were generic guidelines around management of challenging behaviour, there was no evidence that these were individualised to each resident (dementia unit). Oher interventions for each of the residents identified were well documented.	Ensure that interventions are documented to manage challenging events or medical issues. 60 days

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	A DT is responsible for providing the activities programme. The DT was on leave for the week during the audit and an activities programme was not provided for during this time. Caregivers were able to pick up some activities with residents. Goals are documented for each resident around activities following an assessment of interests and discussion with the resident. Interventions to progress goals were not well documented. Twenty-four-hour activity plans were not developed for residents in the dementia unit.	i) The DT was not replaced while on leave and the programme was not provided. ii) An activities plan is not well documented for each resident with interventions identified to meet goals. iii) A 24-hour activities plan was not documented for each resident in the dementia unit that includes their usual routines and activities	i) Provide an activities programme for residents when the DT is on leave. ii) Document an activities plan is for each resident with interventions identified to meet goals. iii) Document 24-hour activities plan for each resident in the dementia unit. 90 days
Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation	PA Moderate	There is a designated smoking area for residents who smoke. In the hospital/rest home area, there were cigarette butts outside the bedroom door of one resident who smokes (not a designated area) and there were two cigarette butts on the bedroom floor. The room smelled of smoke on the days of audit. This resident was asked to wear a fire blanket as they dropped ash and embers on themselves when smoking. One resident (who smoked) stated that they were	There are issues relating to management of residents who smoke that include the potential for residents being asked to supervise another resident who smokes, and the use of areas to smoke outside of the designated area. Since the draft report the provider has stated, there is a smoke area for residents. Staff supervise them when needed. It is not the normal process to ask a resident to supervise another resident who smokes.	Ensure that there is a safe place for residents to smoke with supervision by staff if required. 60 days

and territorial authority requirements.		asked by a staff member on a number of occasions to supervise this resident who smoked (this was not able to be validated by the resident who smoked on the day of audit as they were not able to talk with the auditor, or by staff interviewed). A container with cigarette butts in it was found in the courtyard of the dementia unit outside of the general lounge area.		
Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.	PA Low	The rooms were mostly observed to be clean on the day of audit, however five bedrooms sighted had wheelchairs, had scuffed floors and lower walls with marks not removed. Five residents/family interviewed stated that rooms were not always kept clean. The carpet in the dementia unit was stained.	There are complaints of rooms not being kept clean and this was observed in some areas on the day of audit.	Ensure that rooms are kept clean at all times. 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.