

# South Care Limited - South Care Rest Home & Hospital

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## 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 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:

<b>Legal entity:</b>	South Care Limited
<b>Premises audited:</b>	South Care Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 9 September 2021      End date: 10 September 2021
<b>Proposed changes to current services (if any):</b>	A group structure is under development.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	46

# Executive summary of the audit

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## 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
Yellow	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
Red	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

South Care Rest Home & Hospital (South Care) provides rest home and hospital level care for up to eighty residents in Dunedin. The service is operated by South Care Limited and is managed by an onsite facility manager and a clinical services manager. A general manager and national staff provide support to four facilities across the country. Residents and family/whānau members spoke positively about the care provided.

This is the first full certification audit undertaken under new facility ownership. The audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, external visiting health professionals and a general practitioner.

This audit has identified six areas for improvement relating to review of risks, recording of completion of police vetting for staff, continuity of service delivery, emergency food supplies, cleaning processes for mops and buckets and the need to have a current approved fire evacuation plan.

## 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.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), and these are respected. Personal privacy, independence, individuality, and dignity are supported. Staff interact with residents in a respectful manner.

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect, or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with the single recorded complaint resolved promptly and effectively. Verbal concerns are also documented and acted upon where necessary.

## 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 low risk.
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Business and quality planning is implemented. It includes the scope, direction, goals, values, and the mission statement of the organisation. Regular monitoring of operational activities is undertaken, and performance reported at the monthly management meetings provided. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved through regular meetings and communication, and ongoing feedback is sought from residents and families. Adverse events are documented with corrective actions implemented where necessary. Actual and potential risks, including health and safety risks, are identified, and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. All staff have been through the organisation's new orientation programme since the sale and purchase of the facility. Performance review systems are in place and implemented. A systematic approach to identify and deliver ongoing training and qualifications supports safe service delivery. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## 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 low risk.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The older facility meets the needs of residents and was clean and adequately maintained. An extensive planned maintenance programme has commenced. There is a current building warrant of fitness. Electrical equipment is tested as required and was current.

Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide outdoor seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing which is readily available. Chemicals, hazardous substances, and linen are safely stored. Laundry is now undertaken onsite in a well-equipped laundry. The cleaning team have access to suitable chemicals and equipment to maintain the facility in a clean and hygienic state. Both are evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment, and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells which include a staff pager function. Security is maintained.

## 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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Three enablers were in use at the time of audit. No restraint has occurred in the past year. Processes are in place to ensure suitable approval; assessment implementation and monitoring occurs should this be required.

The use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of enabler processes and strategies for challenging behaviour to minimise the need for any restraint.

## 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.
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The infection prevention and control programme are led by a new infection control coordinator, with support from the clinical manager and a national clinical team with experience in this area. The programme aims to prevent and manage infections and is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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)
<b>Standards</b>	0	40	0	4	1	0	0
<b>Criteria</b>	0	87	0	5	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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	South Care Rest Home & Hospital (South Care) has developed policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
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	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent forms. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day-to-day care.
Standard 1.1.11: Advocacy And	FA	During the admission process, residents are provided with information on the Code, the Nationwide Advocacy Service and on how to make a complaint. This is included as part of the individual resident

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>agreement documentation. Brochures related to the Advocacy Service were available in the facility reception area. Family members and residents spoken with were aware of the Advocacy Service as they attend residents' meetings. They stated they are aware of how to access this service and their right to have support persons. The clinical manager stated that they had no examples of involvement of Advocacy Services but would continue to invite them to be part of the residents' meetings monthly.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits and entertainment.</p> <p>The facility outside of COVID-19 level restrictions, has unrestricted visiting hours, and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints management policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available in several areas in the facility.</p> <p>The complaints register reviewed showed there has been one formal complaint received over the past year and that actions taken, through to an agreed resolution, were documented and completed within the timeframes specified in the Code. An action plans showed the required follow up and improvements have been made to address the issues raised. The facility manager is responsible for complaints management and follow up.</p> <p>Verbal complaints and concerns are documented, including those identified in the resident/family satisfaction surveys, in a verbal complaint register and acted upon where possible. Examples were discussed. The system is through, with residents and families stating that the staff are responsive and list to concerns.</p> <p>Staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Most reported they had raised resident concerns with senior staff.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission process and the admission agreement. The Code is displayed in reception in both English and te Reo Māori together with information on advocacy services, how to make a complaint and feedback forms.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Throughout the audit staff were observed to maintain residents' privacy, and where relevant to give residents choices. All residents have a private room and although there are double rooms, the general manager stated they are only used as singles. This was evident during the audit.</p> <p>Residents are encouraged to maintain their independence as is appropriate to the individual. Two residents were witnessed arranging their own outings to their club. Care plans included documentation related to the residents' abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented and incorporated into their care plan with the resident's consent.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Staff support the two residents in the service who identify as Māori to integrate their cultural values and beliefs to the level of their choice as confirmed by a Māori resident during interview. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available. A Māori resident interviewed reported that staff acknowledge and respected their individual cultural needs and beliefs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. This was confirmed by the relatives spoken with. Resident's personal preferences required interventions and special needs were included in care plans. The resident satisfaction survey confirmed that individual needs are being met. An interdenominational service is held within the facility fortnightly.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. This was confirmed by four visiting health professionals. The induction process for staff included education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, the palliative care team and wound care specialist. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice and that there was an abundance of in-service education provided for them.</p> <p>Other examples of good practice observed during the audit included respectful communication of staff with residents, ensuring residents were happy and providing immediate attention if there was anything they could assist with. The activity programme is diverse and involves residents at both individual and group level.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code.</p> <p>The clinical manager and nurses knew how to access interpreter services through the local hospital but reported this had not been needed to date.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are</p>	<p>FA</p>	<p>The strategic and business plans are reviewed consistently and outline the vision, mission, and values of the organisation. The documents described annual and longer-term objectives of the group and the associated operational plans for the facility. The facility manager provides a monthly report against the objectives to the general manager/owner. Each facility provides comprehensive information about its</p>

<p>planned, coordinated, and appropriate to the needs of consumers.</p>		<p>performance within the group, including progress with quality, business, and clinical indicators. A sample of reports reviewed showed adequate information to monitor performance is reported to support organisational decision making. Regular meetings of the facilities and clinical managers occurs most months via video conferencing, to discuss matters of common interest.</p> <p>A small national operational clinical support team is available to the facility, which includes clinical expertise and support. Roving managers can provide additional support to the facility team and provide back up for the managers during periods of leave. The facility manager is supported by the clinical manager, and a small, registered nurse and health care assistant team for operational matters. Regular meetings with the team are held each month.</p> <p>The owner is a registered nurse holding a current annual practising certificate. The facility manager has medical training and is pursuing post graduate qualification in public health. Other senior staff have completed business qualifications or hold health professional qualifications. The clinical manager is a registered nurse who has worked in the facility prior to the current ownership. They are planning further relevant education. Roles, responsibilities, and accountabilities are defined in job descriptions and individual employment agreements for the management team. The GM and facility manager confirmed knowledge of the sector, the regulatory and reporting requirements and maintain currency through local and national sector updates.</p> <p>The service holds contracts with Southern District Health Board for hospital level medical, geriatric and rest home care including respite care. There twenty-three rest home and twenty-three hospital residents on the day of audit including two under 65-year-old residents with long term support needs.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the facility manager is absent, one of the senior team performs all the required duties under delegated authority. The general manager is also available on call as necessary with contact maintained through 'What's app' and phone contact. During absences of key clinical staff, the clinical management is overseen by the overall (group) clinical manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>PA Low</p>	<p>The organisation has a business, quality risk system and management plan that is implemented and reflects the principles of continuous improvement and domains of quality. Each of the quality goals incorporates these domains and these were well understood by staff. This included management of incidents and complaints, internal audit activities, a regular patient satisfaction surveys, monitoring of</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>outcomes, clinical incidents, including infections, pressure injuries and falls.</p> <p>The owner, GM and facility manager described the processes for the identification, monitoring and reporting of operational business activities. A hazard register identifies specific hazards in the facility and any mitigation necessary. Risks and new or emerging issues are discussed, although there is no specific register identifying priority risk issues, or which incorporate risk-based thinking or mitigation strategies. (Refer 1.2.3.9).</p> <p>Regular staff meetings (“all staff” and registered nurses) provide a forum for discussing quality issues. Meeting minutes and attendance are maintained and follow a set agenda. Three sets of minutes for each meeting were reviewed in detail. This confirmed comprehensive reporting systems and discussion routinely occurs. Regular review of quality indicators is completed, and data is collated, analysed, reported, and discussed at the management team meeting. This is supported by graphed results to aid comparative analysis. Indicators discussed included pressure injuries, restraint/enablers, falls, complaints, incidents/events, infections, audit results and activities. Maintenance issues and training needs are noted. A facility monitoring report is also documented.</p> <p>Staff reported their involvement in quality and risk activities through internal audit activities. Relevant corrective actions are developed and implemented where necessary. Staff, resident, and family surveys are completed at least annually. The last survey showed improving levels of satisfaction, including for the food service.</p> <p>A suite of policies covers all necessary aspects of the service and contractual requirements and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. Staff are updated on new policies or changes to policies through staff meetings and verified that they have read the policy and procedure.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on a hard copy accident/incident form. Residents' documentation reviewed provided evidence of communication with families/next-of-kin/enduring power of attorney (EPOA) following adverse events involving the resident, or any change in the resident's condition, in accordance with the open disclosure policy.</p> <p>A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed-up in a timely manner. Adverse event data is collated, analysed, and reported to staff and management through the regular meetings. Meeting minutes reviewed showed discussion in relation to trends, action plans and improvements are made.</p> <p>Policy and procedures (Accidents and Incidents) described essential notification reporting requirements. This included pressure injuries, health and safety, professional bodies, notifiable</p>

		conditions, the coroner, section 31's). The GM advised there have been no notifications of significant events required or to the Ministry of Health, under the new ownership.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Policies and procedures are developed in line with good employment practice and relevant legislative requirements. Various advertising methods are used for effective recruitment. Position descriptions reviewed were current and defined the key tasks and accountabilities for each role. The recruitment process included referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. These records are systematically maintained, except for completion of the vetting process (refer 1.2.7.3). A sample of staff records reviewed confirmed the organisation's human resources policies are being consistently implemented. Under the new ownership, all staff have undergone a full (re)employment process, including the organisation's full orientation with new personnel records for each staff member. Orientation packs are used for new appointments and records reviewed were well ordered and maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported feeling the orientation process prepared them well and they have a good understanding of what is required of them. Orientation is thorough and included support from a 'buddy' through their initial orientation period. Staff records reviewed showed documentation of completed orientation and a performance review after an initial three-month, then six-month period, then followed by annual appraisals. These were on file for the initial appraisal for new staff and are either underway or scheduled for existing staff who have ben reemployed.</p> <p>Continuing education is planned on a biannual basis according to a comprehensive schedule. Mandatory training requirements are defined and scheduled to occur over the course of two years. Significant training sessions have also been implemented in the last nine months with good attendance by staff noted. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the ARRC agreement. Staff may commence qualifications after successful completion of all orientation and performance review. Presently five staff have commenced or completed level 2, six are at level 3 and three at level four. An external assessor is contracted to support staff on the qualification pathway. Education records reviewed showed completion of the required training. Training records are meticulously maintained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	FA	<p>A documented rationale for determining staffing levels and skill mixes is in place to ensure safe service delivery. The facility has staffing levels that reflected the needs of the residents and in consideration of the fragmented layout of the building. Presently, staffing is in place for the four downstairs wings, while one upstairs wing remains unoccupied. Additional 'float staff' have been rostered as resident</p>



<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>numbers have grown. Levels are adjusted, if necessary, as the needs of resident's change (e.g., for palliative care). There is 24 hour/seven days a week (24//7) registered nurse coverage in the hospital.</p> <p>The minimum number of staff is provided during the night shift and consists of one registered nurse and two caregivers. This is made possible by locating staff to one of the three different stations throughout the facility. An effective afterhours on call roster is in place, with staff reporting good access to advice readily available via 'What's App' when needed. This ensures registered staff always have support from the general clinical manager or other members of the management team.</p> <p>Care staff interviewed reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family members interviewed. Observations and review of three two-week roster cycle samples during this audit confirmed adequate staff cover has been provided and there were no examples of working 'short.' The rostering system also alerts senior staff when staff have worked over the threshold of their rostered hours and contract.</p> <p>The organisation presently does not use bureau staff. Most staff are rostered for a minimum of 32 hours per week which allows flexibility for short notice roster gaps. There are plans to develop a pool of casual staff to supplement the current staff group. This includes registered nurses, which may be redeployed between facilities for short periods, such as to cover an upcoming registered nurse vacancy. Two recently appointed overseas registered nurses have not yet been able to enter the country, creating ongoing staffing challenges. However, the three rosters sighted were covered as required by the aged residential care contract. All clinical staff (registered nurses, health care assistants and diversional therapists/activities coordinators) hold current basic first aid certificates.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP notes. This included interRAI assessment information entered in the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent,</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written</p>

<p>equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>information about the service.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</p> <p>An example reviewed of a patient recently returned following a transferred to the local acute care facility showed the staff of South Care had provided clear and appropriate documentation to assist the receiving hospital understand the care required. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements 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 six-monthly stock checks are performed by the pharmacist who stated there have not been any concerns and controlled drugs are well managed.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range and had been recorded daily.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement</p>

		<p>and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were no residents independently self-administering medications at the time of audit. Three residents were being supported to administer their own medications. These medications are stored in the medication room and are checked by a registered nurse and provided to the residents at the appropriate time. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>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 - 7 September 2021. Recommendations made at that time have been implemented into the menu.</p> <p>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 Ministry of Primary Industries on 8 September 2021. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The chef has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Staff have access to snacks, biscuits, and sandwiches, for residents who may require them outside of usual hours. Special equipment, to meet resident's nutritional needs, is available.</p> <p>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.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for</p>

<p>the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed.</p> <p>There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as a pain scale, nutritional screening, falls risk and risk of pressure injuries, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores support care plan goals and interventions.</p> <p>Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration, with most documentation including progress notes, activity notes, medical and allied health professionals' notations clearly written, informative and relevant. There were some exceptions, such as observed behaviours noted on behaviour charts which were not reflected in documentation in the progress notes. In other examples, changes in care that had occurred, were documented in the resident file, however detail was not verbally passed on to relevant staff unless it had occurred on the previous shift. (Refer criterion 1.3.3.4 for further detail). Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations, and interviews verified that care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent especially when some of the residents present with behaviours that challenge. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by one trained diversional therapist holding the national Certificate in Diversional Therapy and one activities coordinator.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated weekly and as part of the formal six-monthly care plan review.</p> <p>A monthly activities calendar is developed and posted on the notice boards. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through monthly residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme varied and interesting.</p> <p>Activities are offered at times when residents are most physically active and/or restless.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. 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 all infections. 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.</p> <p>Each resident's activity needs are evaluated weekly as recorded in the activities progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor,' residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to wound care specialist and palliative service. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and</p>

choice/needs.		emergency in an ambulance if the circumstances dictate.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Chemicals are not held in sufficient quantities to require a designated chemical handler. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. A change of provider occurred at the time of audit, with training provided to staff by the new supplier.</p> <p>Material safety data sheets were available at locations where chemicals are stored. Staff interviewed knew what to do should any chemical spill/event occur. Spill kits are available.</p> <p>There is provision and sufficient protective clothing and equipment available, and staff were observed using this appropriately.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 10 March 2022) is publicly displayed. Hot water temperatures are maintained and monitored monthly, with a plumber following up any variance.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. This includes a recent appointment of a maintenance person with designated routine and reactive maintenance tasks. There is a system to report minor maintenance issues, with tradespeople providing specialist maintenance where required (e.g., electrical, and plumbing repairs). Certificates of compliance are provided and on file where trades work has been undertaken. Testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of equipment in use. Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted. Some areas of the facility include narrow corridors and the environment was noted to be maintained as clutter free as possible. There is space to store equipment away from thoroughfares.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes seven ensuite bathrooms, with the remainder being shared facilities located conveniently in each of the four wings. An upstairs wing also has suitable bathroom facilities but is not presently being used for residents. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment such as shower chairs and stools are available to promote residents'</p>

<p>facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around safely within their bedrooms. Some bedrooms are designated as doubles; however, none are or are likely to be used for dual occupancy. These rooms provide a more suitable space to accommodate where residents need larger equipment. Rooms are of variable size, but every effort is made to ensure that rooms are suitable for the needs of the resident. Most rooms include an electric bed, and are personalised with furnishings, photos and display of other personal items.</p> <p>There is space to store mobility aids, walking frames and wheelchairs. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The central dining area is spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required, with some more intimate spaces available in some wings. A lounge area is available in each wing and can safely accommodate residents. One is used primarily for activities, with residents seen to move around between public areas. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely and can be easily cleaned. Most of the public areas have vinyl flooring which is easily maintained.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>PA Low</p>	<p>All laundry is now undertaken on site in a dedicated laundry. A new gas washing machine and dryer have been installed offering a range of suitable programmable wash and dry cycles. Residents' personal items are laundered on site (or by family members if requested). Consistent staffing in the laundry has resulted in effective systems and processes and reliable results. The resident surveys and residents interviewed reported improved satisfaction, with the laundry well managed and clothes returned in a timely manner. Laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow, and handling of soiled linen. Staff wear PPE when handling and transporting soiled linen.</p> <p>A small cleaning team were interviewed, and cleaning processes demonstrated. Staff have received appropriate training and access to suitable equipment. A change of chemical provider was occurring during the audit and subsequently completed, with new safety data sheets available at the point of</p>

		<p>use. Staff attended training on the day and could describe the purpose of each item they were using. A large cleaning area storage area and supplies were inspected. Chemicals, trolleys, and buckets were stored in a locked room, however the processes to clean both mops and buckets needs review (see 1.4.6.2). Cleaning and laundry processes are monitored through the internal audit programme, with consistently satisfactory results achieved.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>The service has established policies and guidelines for emergency planning and preparedness. Staff have received training in emergency responsiveness in the past year including trial fire evacuations. A folder containing procedures for various civil defence emergencies, fire and other emergency situations is available to staff. A fire evacuation plan was verified as dating to 1987 but no copy is presently available (see 1.4.7.3). A trial evacuation using staged evacuation occurs six-monthly, with a copy sent to the New Zealand Fire Service, the most recent being in August 2021. The orientation programme includes fire and emergency response. Staff confirmed their awareness of the emergency procedures.</p> <p>Emergency supplies of food are, however, not adequate for the numbers of residents and staff on site (Refer 1.4.7.4). Except for emergency food supplies, there were adequate supplies available for use in the event of a civil defence emergency such as water supplies, blankets, torches, PPE, radios, and gas BBQs to meet the requirements for the number of residents. Monthly checks and stock rotation occurs. Gas cooking is available if needed, however there is no generator available on site. The organisation is reviewing its best options in the event of an extended loss of power. Emergency lighting is available for a few hours and is regularly tested.</p> <p>All staff including non-clinical staff, are trained in Basic First Aid (certificates sighted). Training was completed in May 2021.</p> <p>Residents and families reported staff respond promptly to call bells which are alerted via pagers held by the care staff.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and there are checks of the premises during the night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment</p>	<p>FA</p>	<p>All residents' rooms and communal areas have opening external windows and/or doors. Some rooms have doors that open to outside paved areas.</p> <p>Electric heating is provided with electric panel heaters in rooms, bathrooms, and hallways. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are</p>



that is maintained at a safe and comfortable temperature.		maintained at a comfortable temperature following the installation of additional heating over winter.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the DHB nurse infection control specialist. The infection control programme and manual are reviewed annually (last reviewed in August 2021).</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description that was sighted during the audit. The IPC coordinator is new to the role and is supported by the clinical manager and a national clinical team with experience in this area.</p> <p>Infection control matters, including surveillance results, are reported monthly to the general manager and management team at the managers' meeting, and tabled at the monthly staff meeting. The infection control committee includes the facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management and the care staff. The infection committee meeting forms part of the monthly staff meeting.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Signage is available as per the ministry of health guidelines relating to COVID-19. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The manual has been updated to include requirements for COVID-19. Vaccinations for staff and residents are covered in this document. Staff interviewed understood these responsibilities and described their use of personal protective equipment to help prevent the spread of infection.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator is new to this role, however, has received some instruction from the DHB infection control nurse specialist and is supported by a senior clinical team who have the appropriate skills, knowledge and qualifications. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator and the clinical manager confirmed the availability of resources to support the programme and any outbreak of an infection.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in August 2021 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. There has not been an infection outbreak; however, the IPC nurse and the clinical manager were able to provide details of actions that would be taken if one was thought to occur.</p> <p>Education with residents is on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, gastro-intestinal, respiratory tract and other. The IPC coordinator reviews all reported infections and the associated short term care plans, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends every quarter and this is reported to the management team and staff monthly, which include the representatives of the infection</p>

		control committee. Data is benchmarked externally within the group of other aged care providers.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>South Care operates in a restraint free environment. There have been no restraints used in the past year. Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use enablers. There is also guidance on the use of restraint in the event of an emergency. There is a clear focus on effective strategies to manage any challenging behaviour which is seen as a primary means to minimise the need for restraint.</p> <p>The restraint coordinator has very recently left the organisation. In the interim, the facility clinical manager is the acting restraint coordinator. There is a comprehensive role description outlining the support and oversight of systems for safe enabler use. A sound understanding of the organisation's policies, procedures and practice was demonstrated by staff spoken to. A training session has also been completed as part of the regular mandatory training programme, together with a restraint questionnaire which has been completed as part of the orientation implemented for all staff under the new management.</p> <p>On the days of audit, three residents were using enablers, which were the least restrictive and used voluntarily at their request. One or two bedsides are the only enablers presently used. In each case, consent had been obtained and signed by the GP, the restraint coordinator, and the resident. An enabler register is maintained. Monitoring requirements are detailed in the policy and agreed to by the resident as part of the consenting process. Monitoring forms were maintained for all three enablers. (Refer 1.3.3.4).</p> <p>Restraint and enabler use is documented in the meeting minutes of the staff and registered nurse meetings. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(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;</p> <p>(b) A process that</p>	PA Low	<p>The organisation states that the risk management programme is designed to ensure consistent management of operational risks and that risk management plans are incorporated into business plans to minimise loss exposure.</p> <p>Broader organisational risks associated with quality and risk management are captured as quality goals and objectives in the organisation’s documentation. These cover the key risks occurring in residential care and these are referenced to on site folders for more detail. However, the significance of each organisational risk is not clearly identified in documentation sighted (e.g., likelihood and consequence of the risk), or mitigation strategies recorded, for example, in a risk register.</p>	<p>The frequency of review of identified risks does not reflect the significance of, or any changes in risk which may be occurring. Apart from health and safety and hazards, wider organisational risks are not explicitly discussed or reviewed at the various meetings.</p>	<p>Further development is required to ensure that risks are reviewed at a frequency determined by the severity of the risk and the probability of changes in the status of the risk.</p>

addresses/treats the risks associated with service provision is developed and implemented.				180 days
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>Police vetting is undertaken as a matter of course for all newly appointed staff. Since the change of ownership in November 2020, all existing staff have also undergone a full employment process and organisational orientation, including police vetting, as part of establishing new personnel files. Consent for vetting was present in all nine files reviewed, however not all files evidence receipt of a result to complete the vetting process.</p>	<p>In six of nine personnel files reviewed, there is no record of receipt of the police vetting result recorded.</p>	<p>Implement a system to ensure that receipt of police vetting results are recorded on the personnel file.</p> <p>180 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA Low	<p>Despite a verbal handover occurring, the service is unable to provide evidence of clinical care details handed over between shifts for staff returning from leave. The observed handover occurred verbally and contained details of care related to the previous shift only. Both nurses and health care assistants reported that if they had been away, they had to ask for any changes from other staff. There was no handover documentation readily accessible to care staff.</p> <p>Discrepancies in detail between the care plan and diversional therapy plan of the dietary requirements (diabetic diet) for one resident was noted. This incorrect information was remedied by the clinical manager on the day.</p> <p>Three residents have chosen to use enablers for safety reasons. All three residents, have the required documentation regarding this, i.e., a completed consent for enabler use and the associated monitoring form. However, the use of enablers for safety reasons is not referred to in long-term care plans. There is a disconnection in the</p>	<p>Although verbal handovers do occur between shifts, written handover documentation (history and changes in care needs) is not consistently available to staff e.g., those staff returning from leave.</p> <p>Resident documentation sighted at audit was not fully complete and did not support continuity of care e.g., enabler use and challenging behaviour.</p>	<p>The service is coordinated in a manner that provides continuity in service delivery including current documentation to guide care.</p> <p>180 days</p>

		documentation as the information was not carried through from assessment to the plan of care and this was discussed with two clinical managers on the day. A further example related to a resident displaying challenging behaviour. This is clearly recorded by the health care assistant, on the behaviour record sheet, however there is no equivalent entry about this in the progress notes which was completed by the registered nurse. It is clear from discussions with staff that the registered nurses are kept informed, however in the examples described, details to support continuity of care was not always complete in the resident's documentation.		
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	PA Low	There are implemented processes guided by policy for laundry and cleaning activities. Practices observed shows that mops are washed by hand and not laundered using a suitable machine wash. They are not fully dried before being reuse. A variety of coloured buckets are designated for various areas in the facility and staff are clear on how and when they should use these. Practice does not follow policy, in that mops are left wet after use and the cycle of cleaning does not ensure buckets are cleaned and dried between use. Presently, there is not a satisfactory process for the laundering of mops and cleaning of floor buckets for effective infection control management in the facility.	Processes and practice for managing the cleaning of mops and buckets are not adequate to ensure effective infection prevention.	<p>Implement suitable cleaning and drying processes for mops and buckets.</p> <p>180 days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	The facility has operated as a residential care facility at its current location for more than thirty-four years. Fire and Emergency New Zealand (FENZ) have stated that they do not hold a record of an approved evacuation plan on file but do note that an approved plan existed in 1987. It is unclear what, if any, changes have occurred to the building since that date, however, the 1987 date is the only date referenced by FENZ. No evacuation plan information is held by the property owner. South Care General Manager	There is no record available for a current and approved Fire Evacuation Plan for the facility.	Maintain a record of a current approved Fire Evacuation Plan for the facility.

		plans to discuss this further with the Fire Service in the week beginning 13 September 2021. A satisfactory trial evacuation was conducted by a contracted provider on 13 August 2021.		180 days
Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.	PA Moderate	During inspection of the kitchen, accompanied by the chef and a manager, there was no evidence of the management of non-perishable food to be used in the event of an emergency. It was stated by the manager that the emergency food supply was managed by the chef and held in the kitchen. No evidence was found of purchase, storage, and rotation of sufficient food items to feed the residents and others on site for three days in the event of an emergency. Emergency water supplies on hand are available in the recommended quantities.	The chef is charged with managing the emergency food supply, which was stated to be stored in the kitchen storeroom. Sufficient food for use in an emergency was not sighted during the audit. The chef stated this is not required as food deliveries can occur twice a day if required. No evidence was presented of a system to purchase food in suitable quantities or store and manage food for emergency situations.	There is a system in place to purchase, store and rotate sufficient food items for emergency use to meet the needs of the residents for a period of at least three days.  90 days

## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

No data to display
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End of the report.