Graceful Home No.2 Limited - Shelly Beach Dementia

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

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 0.4 of the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

You can view a full copy of the standard on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Graceful Home No.2 Limited
Premises audited:	Shelly Beach Dementia
Services audited:	Dementia care
Dates of audit:	Start date: 26 August 2022 End date: 26 August 2022

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: 12

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 sections contained within the Ngā Paerewa Health and Disability Services Standard:

- ō tatou motika │ our rights
- hunga mahi me te hanganga │ workforce and structure
- ngā huarahi ki te oranga │ pathways to wellbeing
- te aro ki te tangata me te taiao haumaru │ person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
- here taratahi │ restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. 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 subsections applicable to this service fully attained with some subsections exceeded
	No short falls	Subsections 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 subsections applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some subsections 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 subsections applicable to this service unattained and of moderate or high risk

General overview of the audit

Graceful Home No.2 Limited - Shelly Beach Dementia, provides dementia level of care for up to 13 residents.

The registered nurse role is vacant. Recruitment is in progress. The onsite audit was conducted on 26 August 2022. The owner/director was on leave on this day and was able to be interviewed via phone. The human resource records held by the owner/director were not able to be provided until 8 September 2022 due to unforeseen circumstances.

This unannounced surveillance audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, whānau/family members, the team leader, the owner/director, staff, a community support worker and a general practitioner.

At the last audit areas for improvement were identified in relation to having two staff on duty at all times, medication management and food storage. The staffing and food service issue has been addressed.

At this audit six areas have been identified as requiring improvement. These related to essential notifications, staffing/skill mix, staffing training/education, overdue interRAI assessments and long-term care planning, overdue resident medication reviews and staff medication competency assessment records. An improvement is also required in relation to adverse event management. This is noted as a recommendation in this report.

Ō tatou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Subsections applicable to this service fully attained.

Residents who identified as Māori said they were treated equitably and that their self-sovereignty/mana motuhake was supported. The service is socially inclusive and person-centred. Te reo Māori and tikanga Māori are incorporated into daily practices. There is a recruitment programme which includes recruiting and training a Māori health workforce.

Residents and relatives interviewed confirmed that they are treated with dignity and respect. There was no evidence of abuse, neglect, or discrimination.

One complaint has been received since the last audit. Whanau interviewed were aware of the complaints process. Compliments are also being documented.

Hunga mahi me te hanganga | Workforce and structure

Includes 5 subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

The owner/director has expertise in cultural safety and Tikanga and works to reduce barriers for prospective residents in accessing care.

There is a quality and risk programme in place. Internal audits are being completed. Organisation risk is reviewed. Hazards are identified and actions taken to mitigate these.

There is a minimum of two care staff on duty at all times. Staff are provided with an orientation relevant to their role.

The professional qualifications of employed and contracted registered health professionals is validated.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes 8 subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Shelly Beach Dementia has policies and procedures that provide documented guidelines for access to the service. Residents are assessed before entry to the service to confirm their level of care. A registered nurse (RN) is responsible for the assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs and routines. Interventions are appropriate and evaluated as required.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activity plans are completed in consultation with family/whānau and residents noting their activities of interest. Twenty-four-hour activity care plans are in place. In interviews, residents and family/whānau expressed satisfaction with the activities programme.

There is a medicine management system in place. The policies and procedures require medications to be reviewed by the general practitioner (GP) every three months and staff medication competencies completed annually.

The food service provides for specific dietary likes and dislikes of the residents. Nutritional requirements are met. Nutritional snacks are available for residents 24 hours a day, seven days a week.

Residents are referred or transferred to other health services as required.

Te aro ki te tangata me te taiao haumaru | Person-centred and safe environment

Includes 2 subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Subsections applicable to this service fully attained.

The building has a current building warrant of fitness. Electrical equipment has had test and tagging completed and clinical equipment has current performance monitoring and calibration. The owner/director has an understanding of cultural considerations related to building design/renovation.

There is an approved fire evacuation plan and regular files drills are conducted. Security arrangements are appropriate to the service setting.

Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

Includes 5 subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.		Subsections applicable to this service fully attained.

There is a pandemic preparedness plan in place. There are sufficient infection prevention resources including personal protective equipment (PPE) available and readily accessible to support this plan if it is activated.

Surveillance of health care associated infections is undertaken, and results shared with all staff. Follow-up action is taken as and when required. There was an infection outbreak of Covid-19 in March 2022 and this was managed well according to policy guidelines and legislative requirements.

Here taratahi | Restraint and seclusion

Includes 4 subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service fully attained.

The service has been restraint free since before the last audit and aims to maintain a restraint free environment. This is supported by the governing body and policies and procedures. There were no residents using restraints at the time of audit. Staff interviewed demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques and alternative interventions to prevent to use of restraint.

Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	16	0	0	3	1	0
Criteria	0	41	0	0	5	1	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)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Ngā Paerewa Health and Disability Services Standard

The following table contains the results of all the subsections assessed by the auditors at this audit. Depending on the services they provide, not all subsections are relevant to all providers and not all subsections are assessed at every audit.

There may be subsections in this audit report with an attainment rating of 'not applicable' which relate to new requirements in Ngā Paerewa that the provider is working towards. The provider will be expected to meet these requirements at their next audit.

For more information on the standard, please click here.

For more information on the different types of audits and what they cover please click here.

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	The owner/director has extensive experience in Tikanga and cultural safety and stated being committed to having Māori staff in a variety of roles and described processes that have been undertaken for recruitment. However, there are challenges recruiting staff at the time of audit, so ensuring there are sufficient appropriate staff to provide safe service delivery is the current priority rather than the ethnicity of staff. There are staff that identify as Māori.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve	Not Applicable	There are residents and staff that identify as Pasifika, with at least five different nationalities represented. A policy that includes a Pacific model of care is expected to be introduced in the next three to four months.

tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.		
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	The Code of Health and Disability Service Consumer Rights (the Code) is available and displayed in English and Māori throughout the facility. Two residents interviewed, one (respite), one (under community mental health) and Enduring power of attorney (EPOA)/whānau/family of residents who identify as Māori reported that all staff respected the residents and family members rights, that they were supported to know and understand their rights and that their mana motuhake was recognised and respected. Enduring power of attorney (EPOA)/whānau/family or their representative of choice are consulted in the assessment process to determine residents' wishes and support needs when required. The service is guided by the cultural responsiveness for Māori residents' policy when required for residents who identify as Māori.
Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.	FA	The organisation orientation checklist has a section where the staff member is required to read and understand the principles of Te Tiriti o Waitangi. Staff had completed training on the Te Tiriti o Waitangi to support the provision of culturally inclusive care. The service has acknowledged tikanga practices in the policies and procedures reviewed and in the Māori care planning process. Policies and procedures are being updated to ensure that te reo Māori and tikanga practices are incorporated in all activities undertaken. Whānau reported that the resident's values, beliefs, and language is respected in the care planning process. The service responds to residents' needs including those with a disability and supports and encourages participation in te ao Māori.

Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	The team leader stated that any observed or reported racism, abuse or exploitation is addressed promptly and they are guided by the staff code of conduct. In discussion with staff, they acknowledge systemic racism as being a matter that they are aware of within the wider community and working to identify the level of institutional racism within the service (if any) and further determine actions that will be taken to address this issue. Residents and family/whānau expressed that they have not witnessed any abuse or neglect, they are treated fairly, they feel safe, and protected from abuse and neglect. A Māori health model is used when required to ensure a strengths-based and holistic model ensuring wellbeing outcomes for Māori. There are monitoring systems in place, such as family satisfaction surveys to monitor the effectiveness of the processes in place to safeguard residents.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.	FA	The service ensures that guidance on tikanga best practice is used and understood by staff. This was confirmed by residents and whānau in interviews conducted. The team leaders stated that additional advice can be accessed from the local cultural advisors or Te Whatu Ora - Health New Zealand if required. Staff reported that they are encouraged to refer to the Māori Health Policy on tikanga best practice.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.	FA	A fair and transparent complaint management system is in place to receive and resolve complaints that lead to improvements. This meets the requirements of the Code. A process to ensure complaints process works equity for Māori will be introduced later in 2022.

Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.		There have been no complaints received directly from residents or family by the managers in the past 12 months as identified by the team leader and the owner/director. Whānau understood their right to make a complaint and knew how to do so. They informed they feel free and comfortable about raising any issue of concern. One family member indicated some agreed regular communication update processes had not been implemented as planned, however has not made a complaint about this, and is overall satisfied with services. One anonymous complaint was received by Te Whatu Ora Waitemata (TWOW) in March 2021 and was subsequently closed as not substantiated. The team leader and the owner/director are currently responsible for complaints management. No complaints have been received by the Ministry of Health (MOH) or Accident Compensation Corporation (ACC) since the last audit. There have also been written compliments received about services. Examples of these were sighted.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a high-quality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	FA	The owner/director discussed the potential barriers for residents accessing services and strategies to reduce those for Māori. The owner director has lived expertise in Te Tiriti and cultural safety and stated fostering Tikanga and cultural safety practices for all residents and staff is central to all aspects of service delivery at Shelly Bay Dementia Care. The owner/director and staff have yet to undertake training on equity for Māori and tāngata whaikaha although this is planned.
Subsection 2.2: Quality and risk	PA Moderate	The organisation has a planned quality and risk system that is stated

The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.		to include the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit activities, satisfaction surveys, monitoring of outcomes, policies and procedures, health and safety reviews and clinical and non-clinical incident management. The team leader and the registered nurse are responsible for implementation of the quality and risk system with the assistance of the owner/director. The RN role is currently vacant since 18 August 2022 (refer to the area for improvement in 2.3.1). The owner/director advised being responsible to assist the team leader with oversight of all quality and risk management activities in the interim. A whānau satisfaction survey was undertaken earlier in 2022 with whānau being offered the opportunity of providing feedback. The team leader advised there was about three responses received, however was unable to locate the completed documents during audit. It was though these may have been forwarded to the owner/director for review. There are a range of internal audits, which are undertaken using template audit forms and according to a schedule. The results are reported to relevant staff and discussed by the management team. Relevant corrective actions are developed and implemented to address any shortfalls. Organisational policies, procedures and associated documentation have been developed by an external consultant. The facility/owner advised the service will be transitioning to a new quality and risk management system over the next three to four months and this will include introducing a new suite of policies and procedures that will align with the Nga Paerewa standards. Health and safety systems are being implemented according to the health and safety policy by the team leader. There is a current hazardous substance register that was last reviewed in June 2022. All hazards reported in 2022 have been investigated and addressed.

		There is a current hazard register. A risk management plan is in place. The owner/director confirmed changes or the identification of any new risk, including those related to individual resident's care, are brought to their attention promptly. Shelly Bay Dementia Care has not yet included potential inequities in the organisational risk management plan. There are staff meetings occurring using a template agenda. While the owner/director aims to meet with staff one – two monthly this has not occurred in 2022 due to Covid 19 and other issues. Two meetings have occurred year to date. The meeting minutes sighted included discussion on relevant resident and facility quality and risk issues including hazards, training, staffing, adverse events, and changes in process/systems including those related to Covid-19 management. Staff confirmed they feel well informed and well supported. While there is satisfaction with services provided there is not yet a critical analysis of organisational practices at the service/operations level aimed to improve health equity within the Shelly Bay Dementia Care services. The service is not required to comply with the National Adverse Event Reporting Policy. While staff document adverse and near miss events, incidents were not consistently investigated, action plans developed and actions followed-up in a timely manner. This is an area requiring improvement. There are processes in place in relation to essential notifications. Not all applicable events are being reported, and this also requires improvement.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved	PA High	There is a documented process for determining staffing levels and skill mixes to provide clinically safe care, 24 hours a day, seven days a week (24/7). Rosters are adjusted in response to resident numbers and level of care and when residents' needs change. There are two staff on duty at all times. The shortfall from the last audit has been addressed.

through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.		An area for improvement is identified in relation to the registered nurse role being vacant and not having at least one staff member on duty who has a current first aid certificate and medication competency. With the exception of orientation (refer to 2.4), there has been limited ongoing education provided. This is an area requiring improvement. The owner /director has plans to include the use of high quality Māori health data and provide training on health equity and training as part of future education plans.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	FA	Staff are provided with an orientation relevant to their role. This includes completion of a checklist with skills and key information that is to be covered. Some aspects are completed by the team leader and other components by the registered nurse. Contracted registered health professionals have a current annual practising certificate. These are monitored by the owner and director and documents sighted included the GP, the previous RN, the podiatrist and the pharmacists. The ethnicities of staff are known. Staff related information is stored securely.
Subsection 3.1: Entry and declining entry The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We	Not Applicable	An admission policy for the management of inquiries and entry to service is in place. All enquiries and those declined entry are recorded on the pre-enquiry form. The team leaders interviewed reported routine analysis to show entry and decline rates is going to be recorded to comply with the requirements of the new standards. Specific data for entry and decline rates for Māori will be included where applicable. There were Māori resident(s) at the time of audit. The service is actively making contacts to work in partnership with local Māori communities and organisations. The team leaders stated that Māori health practitioners and traditional Māori healers for residents and whānau who may benefit from these interventions will

focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.		be consulted when required.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Moderate	All files sampled identified that initial assessments and initial care plans were resident centred, and these were completed within the required time frames. Both a paper-based and electronic (interRAI) record management systems is used. The service uses assessment tools that include consideration of residents' lived experiences, cultural needs, values, and beliefs. Nursing care is undertaken by appropriately trained and skilled staff. The RN cover is currently provided by a nurse for acute issues by another RN working in a care home owned by the owner/director. The GP completes the residents' medical admission within the required time frames and conducts medical reviews promptly. Completed medical records were sighted in all files sampled. Residents' files sampled identified service integration with other members of the health team. Multidisciplinary team (MDT) meetings were completed annually. The team leaders reported that sufficient and appropriate information is shared between the staff at each handover. Interviewed staff stated that they are updated daily regarding each resident's condition. Progress notes were completed on every shift and more often if there were any changes in a resident's condition. All residents, including respite resident, were evaluated on each shift and reported in the progress notes by the care staff. Short-term care plans were developed for short-term problems or in the event of any significant change with appropriate interventions formulated to guide staff. The plans were reviewed weekly or earlier if clinically indicated by the degree of risk noted during the assessment process. These were added to the long-term care plan if the condition did not resolve in three weeks. Any change in condition is reported to the RN and this was evidenced in the records sampled. Interviews verified residents

		and EPOA/whānau/family are included and informed of all changes. Long-term care plans were not consistently reviewed following interRAI reassessments. Where progress was different from expected, the service, in collaboration with the resident or EPOA/whānau/family responded by initiating changes to the care plan. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs. The EPOA/whānau/family and residents interviewed confirmed their involvement in the evaluation of progress and any resulting changes. The Māori Health Care Plan in place reflects the partnership and support of residents, whānau, and the extended whānau as applicable to support wellbeing. Residents' principles are included within the Māori Health Care Plan. Any barriers that prevent residents and whānau from independently accessing information or services would be identified and strategies to manage these documented. This includes residents with a disability. The staff confirmed they understood the process to support residents and whānau. An improvement is required in relation to completing interRAI assessments in a timely manner, updating long-term care plans following completion of interRAI assessments, and ensuring interRAI assessments accurately reflect current falls data and appropriate interventions are identified on the long-term care plans.
Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which	FA	Activities are currently being conducted by health care assistants. The team leaders reported that the service supports community initiatives that meet the health needs and aspirations of Māori and whānau. Residents and whānau interviewed felt supported in accessing community activities such as celebrating national events, such as Matariki holiday, and local visits from schools. The planned activities and community connections are suitable for the residents. Opportunities for Māori and whānau to participate in te ao Māori are facilitated. Van trips are conducted once a week except under COVID-19 national restrictions.

are suitable for their age and stage and are satisfying to them.		Family/whānau and residents reported overall satisfaction with the level and variety of activities provided.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The medication management policy is current and in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management (an electronic system) is in use. This is used for medication prescribing, dispensing, administration, review, and reconciliation. Administration records are maintained. Medications are supplied to the facility from a contracted pharmacy. Indications for use are noted for pro re nata (PRN) medications, including over-the-counter medications, and supplements, allergies are indicated, and all photos were current. Eye drops in use were dated on opening and these were sighted in the medication trolleys. There were no expired or unwanted medicines and expired medicines are returned to the pharmacy promptly. Monitoring of the medicine fridge and medication room temperatures is conducted regularly and deviations from normal were reported and attended to promptly. Records were sighted. The controlled drug register was current and correct. Weekly and six-monthly stock takes had been conducted. The team leader reported that controlled drugs are stored securely following requirements and checked by two staff for accuracy when being administered and records were reviewed to confirm this. On the day of the audit there were no residents on controlled medications. Outcomes of PRN medications were consistently documented. The team leader was observed administering medications safely and correctly. Medications were stored safely and securely in the trollies, locked treatment rooms, and cupboards. There were no residents self-administering medications. Self-administration of medication is not encouraged due to the residents' impaired cognitive state. There were no standing orders in use. The medication policy clearly outlines that residents', including Māori residents and their whānau, are supported to understand their

		medications. The policies and procedures require all staff who administer medication to have medication competencies completed annually, however some medication competencies for staff currently administering medicines could not be verified. This is an area requiring improvement. The previous area requiring improvement relating to documenting PRN outcomes was addressed, however, completion of GP three monthly medication reviews remains open as two medication charts were overdue for review.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	The menu was reviewed by the registered dietitian on 18 July 2021. Māori health plan in place included cultural values, beliefs and protocols around food. The team leader stated that menu options are culturally specific to te ao Māori/cultural, 'boil ups' were included on the menu and these are offered to Māori residents when required. EPOA/whānau/family are welcome to bring culturally specific food for their relatives. The interviewed residents and EPOA/whānau/family expressed satisfaction with the food portions and options. The previous areas requiring improvement in relation to menu review and disposing of meat that had past the use-by date have been addressed.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services.	FA	A standard transfer notification form from Te Whatu Ora - Health New Zealand is utilised when residents are required to be transferred to the public hospital or another service. Residents and their EPOA/whānau/family were involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this. Records sampled evidenced that the transfer and discharge planning included risk mitigation and current residents' needs. The discharge plan sampled confirmed that, where required, a referral to other allied health providers to ensure the safety of the resident was completed.

We work alongside each person and whānau to provide and coordinate a supported transition of care or support.		
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	FA	The building has a current building warrant of fitness (BWOF) with expiry 2 June 2023. Clinical equipment has evidence of current performance monitoring/clinical validation. Electrical test and tagging of electrical appliances occurred on 19 August 2022. The owner/director has appropriate knowledge to ensure any future building design reflects the aspiration and identify of Māori. Whanau interviewed were happy with the environment and that the cultural needs of their loved one was being met.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	FA	There is a fire evacuation plan that has been approved by Fire and Emergency New Zealand on 12 August 2009. Staff are provided with training during orientation. A fire evacuation drill was last conducted on 16 August 2022 and records sighted. There is a resident register that details the names of all residents and the level of care required in the event of a fire or other emergency. Security is appropriate for a secure dementia care unit. A visitor's register is maintained with all visitors required to sign in and complete Covid -19 screening requirements. There are security cameras monitoring external areas and internally in designated areas. Signage alerts that cameras are in use. Archived images are accessible by the owner/director and the previous RN when employed. Images are displayed in real time in a staff area.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing	FA	A pandemic plan is in place, and this is reviewed at regular intervals. There was an infection outbreak of COVID-19 from 13 March 2022 to 26 March 2022 and a total of 10 residents were affected. The outbreak was managed according to MoH guidelines and requirements. Sufficient infection prevention (IP) resources including

policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.		personal protective equipment (PPE) were sighted. The IP resources were readily accessible to support the pandemic plan if required. The service is actively working towards including infection prevention information in te reo Māori. They are also working towards ensuring that the infection prevention personnel and committee work in partnership with Māori for the protection of culturally safe practices in infection prevention and acknowledging the spirit of Te Tiriti. In interviews, staff understood these requirements.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	Surveillance of healthcare-associated infections (HAIs) is appropriate to that recommended for long-term care facilities and is in line with priorities defined in the infection control programme. Results of the surveillance data are shared with staff during shift handovers, at staff meetings. The team leaders reported that the GP is informed on time when a resident had an infection and appropriate antibiotics were appropriately prescribed for all diagnosed infections. Culturally safe processes for communication between the service and residents who develop or experience a HAI are practised. The service is actively working towards including ethnicity data in the surveillance of healthcare-associated infections programme.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	The owner /director advised a commitment to maintaining a restraint free environment at Shelly Bay Dementia Care, and no restraints have been used since the last audit. The focus is on de-escalation and individualised resident processes for diversion, distraction and managing challenging behaviour. These are detailed in resident care plans as sighted at audit. The gerontology nurse specialist provided training to staff on dementia and behaviour that challenge on 20 October 2020. Staff interviewed confirmed restraints are not in use. A non-restraint audit was undertaken by the team leader in March 2022.

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our 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 2.2.6 Service providers shall understand and comply with statutory and regulatory obligations in relation to essential notification reporting.	PA Moderate	The owner/director advised essential notifications has been made since the last audit. This related to not having a registered nurse for a period of time starting January 2022, and a Covid-19 outbreak. The owner/director could detail the other types of events requiring notification including serious harm, outbreaks, stage three pressure injuries and loss of key utilities. However, several events have not been notified when required. This included the recent resignation of the RN on 15 August 2022 and there is currently a gap until a new RN is recruited. In the interim the owner/director advised care staff can contact a RN at another specified care home opened by the owner/director for advice or the GP if required for urgent clinical issues. An RN to provide the specified services as	Not all essential reporting events are being reported to comply with statutory and regulatory obligations.	Ensure all essential reporting events are being reported to the appropriate authority/agency in a timely manner to comply with statutory and regulatory obligations. 90 days

		required by the aged related residential care contract for oversight of resident care was not available. This is included in the area for improvement raised in 2.3.1. One resident was absent from the facility without leave and was brought back by the police after four hours, and on another occasion, police were called to the care home. These events have not been notified as per interview with the owner/director although the team leader confirmed, and resident clinical records detailed that the Te Whatu Ora Waitemata clinical staff were notified and provided the resident and care home with clinical support.		
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	PA High	A review of the roster identifies there are at least two care staff on duty at all times, one of whom is a senior. Same care staff are willingly working 12-hour shifts while recruitment for another caregiver occurs. The care staff undertaken some cleaning and the laundry duties over a 24-hour period as resident care needs permits. A designated cleaner also works at least 27 hours per week. Records were only available to demonstrate that only one care staff has a current first aid certificate. Two other staff are booked to undertake training on 25 October 2022. Care staff confirmed there were adequate staff to complete the work allocated to them. Whānau interviewed supported this. Records were not available to demonstrate there is a staff member on duty at all times	Records are not available to demonstrate there is a staff member on duty at all times with a current first aid certificate and medication competency. The registered nurse role is currently vacant (since 18 August 2022) when the RN resigned. Recruitment for a replacement is underway.	Ensure records are available to demonstrate that there is a staff member on duty at all times with a current first aid certificate and medication competency and records are available. Employ a registered nurse to have oversight of resident's clinical care and undertake the roles and responsibilities as detailed in the aged related residential care contract. 30 days

		with a current medication competency. Refer to 3.4.3. The roster available noted the RN resigned with their last day being 18 August 2022. A new RN has yet to be employed. While care staff can contact a RN working in one of the owner/director's other care home for advice in an emergency, there is not a RN on site to provide the oversight direction and delegation and clinical care responsibilities as required by the aged related residential care contract. Please also refer to 2.2.6. There is a staff member rostered daily for cooking. An activities coordinator had been employed but has recently resigned. A new staff member has been employed but is yet to start. In the interim, the care staff are facilitating the daily activities programme.		
Criterion 2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.	PA Moderate	The only training plans/schedules sighted were dated 2020 and 2021. The owner/director confirmed a training plan has not yet been developed for 2022, but one will be developed and will be based on meeting the Nga Paerewa standards, resident care needs and the aged related residential care contract requirements. The owner/director advised there was significant disruption to training opportunities that were caused by Covid 19 and associated restrictions. Interviews with the team leader and care staff confirmed that with the exception of orientation, the only in-service training that has occurred since March 2021 has been on	A training plan for 2022 has yet to be developed. There has been limited training provided to staff in 2021 and 2022 as per training records sighted and staff interviewed.	Develop and implement a training plan that is appropriate to the services provided and aligned with aged related residential care contract and Nga Paerewa standards, and ensure appropriate records are retained. 90 days

		the code of rights/advocacy, fire evacuation drills and infection prevention and control topics including covid 19, appropriate use of personal protective equipment (PPE) and hand hygiene. There are three staff that have completed and industry approved qualification in dementia care. Six staff employed for less than 18 months have been recently enrolled to undertake an industry approved qualification in dementia care. Three of these staff completed a different industry approved qualification prior to employment.		
Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure	PA Moderate	Residents long-term care plans were developed however these were not updated within the required time frames following completion of interRAI re-assessments. One resident's interRAI assessment did not accurately reflect current falls data, noted no falls in the last 90 days when resident had two falls within that period, and two more subsequently. Furthermore, this risk was not identified on the long-term care plan. InterRAI assessments are required to be completed as per policy and legislative requirements, however two residents interRAI assessments were not completed in a timely manner and last completed in June 2021. Cultural assessments were completed by the RN in consultation with the residents, family/whānau/EPOA. Having interRAI assessments not reflecting current falls data, and this not being identified on the long-term care plans and consequently long-term care plans not evaluated in a timely manner has the potential of putting the residents at	(ii) Four out of five residents' long-term care plans have not been updated following completion of interRAI assessments. (ii) One resident's interRAI assessments did not accurately reflect current falls data in the 90 days prior to the InterRAI assessment being completed and falls prevention strategies were not adequately identified in the long-term care plan. (iii)Two out of 11 residents did not have current interRAI assessments in place, last completed in June 2021.	(i)Ensure all long-term care plans are evaluated following completion of interRAI assessments. (ii)Ensure interRAI assessments and long-term care plans reflect resident's current care needs such as falls. (iii)Ensure all interRAI assessments are completed within the required timeframes. 90 days

changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.		safety risks for example, of falls, and experiencing other medical risks. Resident, family/whānau/EPOA, and GP involvement is encouraged. Twenty-four-hour activity plans were in place. Neurological observations for unwitnessed falls were not consistently completed (refer to 2.2.5).		
Criterion 3.4.2 The following aspects of the system shall be performed and communicated to people by registered health professionals operating within their role and scope of practice: prescribing, dispensing, reconciliation, and review.	PA Moderate	Medication reconciliation is conducted by the RN and team leaders when a resident is transferred back to the service from the hospital or any external appointments. The staff checked medicines against the prescription, and these were updated in the electronic medication management system. The GP is required to complete three monthly medication reviews as per policy and legislative requirements; however, two resident medication charts were overdue for review by one to two months. This previous corrective action remains open. The team leader reported that the GP was going to be informed on the next visit. The non-review of medicines in a timely manner may potentially result in polypharmacy or residents getting medication they no longer need.	Two out of 11 residents' medication charts were overdue for review, due in June and July 2022 respectively.	Ensure three monthly medication reviews are completed within the required timeframes. 90 days
Criterion 3.4.3 Service providers ensure competent health care and support workers manage medication including:	PA Moderate	Records are available to demonstrate that two care staff have current competency for insulin administration and one care staff has current competency for oral medication administration, completed in October 2021.	Records were not available to demonstrate all applicable care staff have a current medication competency.	Ensure records are available to demonstrate all staff administering medications have a current medications competency assessment and

receiving, storage, administration, monitoring, safe disposal, or returning to pharmacy.		While two caregivers interviewed advised they had competed medication competency with the RN after their employment, the competency assessment records could not be located. Another carers most recent available medication competency was noted as being completed in October 2020. One of the care staff was observed to competently administer medication during the observed medication round. Medication incidents were completed in the event of a medication error or omissions as sighted during the audit. The event review process did not include verifying that the applicable staff member had a current medication competency (refer to area for improvement raised in 2.2.5).		this is reviewed annually. 30 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

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