# Aberleigh Rest Home Limited - Aberleigh Rest Home

## 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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to Manatū Hauora (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 Manatū Hauora website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Aberleigh Rest Home Limited

**Premises audited:** Aberleigh Rest Home

**Services audited:** Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 31 January 2024 End date: 1 February 2024

**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:** 56

# 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 tātou 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 are fully attained with some subsections exceeded |
|  | No short falls | Subsections applicable to this service are 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 are partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some subsections applicable to this service are 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 are unattained and of moderate or high risk |

## General overview of the audit

Aberleigh Rest Home is part of the Dementia Care New Zealand group, providing rest home, hospital, dementia, and psychogeriatric level of care for up to 62 residents. On the day of audit, there were 56 residents.

This certification audit process was conducted against the Ngā Paerewa Health and Disability Services Standard and the contracts with Te Whatu Ora Health New Zealand- Nelson Marlborough. The audit processes included observations, a review of organisational documents, staff, and resident files, interviews with family/whānau, management and governance representatives, and a nurse practitioner.

The operation manager has been in the role since 2014. The clinical manager is appointed in her role in November 2023. They are both supported by the clinical governance group.

Corrective actions required from previous audit around staffing, and timeframes of assessments remain open.

This unannounced surveillance audit identified shortfalls around complaint management; training; performance appraisals; internal audit follow-ups; assessment and care plan monitoring and evaluations; medication management; and equipment checks.

## Ō tātou 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. |  | Some subsections applicable to this service are partially attained and of low risk. |

There are policies in place to ensure Māori and Pasifika world views of health in service delivery would be supported for any Māori or Pasifika residents and their whānau. The service embraces inclusivity across all ethnicities and regularly celebrates cultural diversity through cultural days.

Annual education sessions focused on preventing abuse and neglect, emphasising respect and dignity for older persons. During the interview, staff demonstrated a keen awareness of abuse signs and proper escalation procedures. The employment process includes police checks.

Whānau and legal representatives are involved in decision making that complies with the law. Details on the procedure for filing a complaint are easily accessible to residents and their families/whānau. The process for complaints is communicated to them.

## Hunga mahi me te hanganga │ Workforce and structure

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

The service has an established quality and risk management programme, incorporating internal audits, collection of clinical indicator data, and benchmarking with their facilities for performance monitoring. The audit schedule has been implemented. Staff and family/whānau surveys are conducted annually.

The service has an induction programme in place that provides new staff with relevant information for safe work practice. A training programme is in place, and staff also engage in self-directed learning through training packages. A health and safety programme is implemented, which includes hazard reporting and management of staff wellbeing.

## Ngā huarahi ki te oranga │ Pathways to wellbeing

|  |  |  |
| --- | --- | --- |
| Includes eight 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 are partially attained and of medium or high risk and/or unattained and of low risk. |

The registered nurses (RNs) are responsible to assess, plan and review residents' needs, outcomes, and goals. Progress noted evidence of service delivery. Staff receive a comprehensive handover between shifts.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers are responsible for the administration of medications. A medication competency schedule is in place.

The kitchen staff cater to individual cultural and dietary requirements. The service has a current food control plan. Nutritional snacks are available for residents 24 hours a day. Residents were complimentary of the food services.

All residents’ transfers and referrals are coordinated with residents and families/whānau.

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

|  |  |  |
| --- | --- | --- |
| Includes two 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. |  | Some subsections applicable to this service are partially attained and of low risk. |

The building has a current warrant of fitness and an approved fire evacuation scheme. There is a planned and reactive maintenance programme in place.

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

|  |  |  |
| --- | --- | --- |
| Includes five 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 are fully attained. |

The infection prevention and control policies reflect the requirements of the standard and are based on current accepted good practice. Surveillance of infections within the facility is appropriate for its size and complexity of the service and it is linked to the quality and risk management system. The service captures ethnicity data for Māori. There has been one Covid-19 outbreak in 2023. The outbreak was contained in one of the wings and was managed well.

## Here taratahi │ Restraint and seclusion

|  |  |  |
| --- | --- | --- |
| Includes four 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 are fully attained. |

The restraint coordinator is the clinical manager. The facility had no residents using restraints at the time of the audit. Encouraging a restraint-free environment is included as part of the education and the annual training plan. The service considers the least restrictive practices, implements de-escalation techniques, and only uses an approved restraint as a last resort.

## 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 | 11 | 0 | 3 | 1 | 3 | 0 |
| **Criteria** | 0 | 37 | 0 | 4 | 4 | 4 | 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.

For more information on the standard, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | There is a Māori health plan that acknowledges Te Tiriti o Waitangi as a founding document for Aotearoa, New Zealand. Dementia Care NZ Strategic plan includes priorities around implementation of their Māori health plan and elimination barriers to providing culturally appropriate services to Māori and promotes mana motuhake. Dementia Care NZ “vision, values and the work that we do”, statements are widely distributed in te reo Māori and English. The governance body monitors key metrics on equity, including the number of staff and residents identifying as Māori. Interviews with staff (two RNs, four caregivers, a cook and an activities coordinator). described examples of providing culturally safe services in relation to their role. |
| 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 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. | FA | The Pacific Health Plan is documented. If required, the service can access pamphlets and information on the service in most Pacific languages. Annual family survey results showed around 82.7% satisfaction with how resident’s cultural and spiritual needs are addressed; 17.2 % of responders were marked neutral with their decision about this.  The best friend model of care includes cultural self-determination principles, which staff attended this training in 2023. Expectations around cultural principles were documented on staff job descriptions. Staff files reviewed evidenced that staff complete self-directed training around Pacific health. In an interview, the managing director explained their ongoing collaboration with cultural organisations to provide support for their residents in care. |
| 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 | Residents and their families/whānau have access to information about the Code of Health and Disability Services Consumers’ Rights, which is prominently displayed in both English and te reo Māori. Upon admission and during family/whānau meetings, the operations manager or clinical manager explains the Code's relevance, ensuring understanding and compliance. Additionally, information about the Nationwide Health and Disability Advocacy Service is readily available to residents/family/whānau. Meetings for residents and relatives offer opportunities to voice any concerns.  Staff members are well-versed in the Code. They understand its implications for their roles and duties. This was confirmed in the staff interviews. Staff receive comprehensive education about the Code of Rights during orientation and ongoing annual training, which covers the importance of advocacy services and their integration into the complaints process.  Interviews with two rest home residents and eight family/whānau (two hospital, two dementia, two rest home and two psychogeriatric unit) affirm that the facility upholds residents' rights, treating them with dignity, respect, and kindness. |
| 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 service actively promotes education on cultural safety, abuse and neglect awareness, professional boundaries, and diversity training. Staff members are not only encouraged to address these issues but are also provided with management support if they feel uncomfortable doing so. The service embraces inclusivity across all ethnicities and regularly celebrates cultural diversity through cultural days.  During new employee induction, a comprehensive staff code of conduct is thoroughly discussed. Professional boundaries are clearly outlined in job descriptions, and interviews with RNs and caregivers confirmed their understanding of these boundaries, encompassing the expectations of their roles and responsibilities. Professional boundaries are also covered in the orientation process.  Staff education programme emphasises the importance of valuing older people and showing them respect and dignity. In interviews, residents consistently affirmed that staff members are caring, supportive, and respectful. Relatives echoed these sentiments, confirming the excellent care provided to their family members. Staff members demonstrated a clear understanding of the signs and symptoms of abuse and were knowledgeable about the appropriate escalation procedures for their concerns.  Police checks are completed as part of the employment process. The service is committed to safeguarding residents' properties and finances by implementing protocols and transparent practices in all financial and property-related matters. |
| 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 processes for obtaining informed consent were thoroughly addressed with residents, family/whānau, during admission. The family/ whānau interviewed stated they are provided with a choice when treatment is discussed. The informed consent process follows the guidelines of the Code of Health and Disability Services Consumers’ Rights. Staff completed education in Code of Rights. Files reviewed had all completed informed consent documents on file. Enduring power of attorney (EPOA) is activated for residents where required. There are letters of EPOA activation signed by a medical practitioner related to diminished competence on file for the residents in the dementia unit and psychogeriatric unit. Caregivers affirmed their awareness of the requirements for obtaining informed consent, especially when entering rooms and providing personal care. Relatives survey 2023 results show that 82.7%of respondents were happy with how consent processes were implemented, and 6.9% responded neutral. |
| 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. 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. | PA Low | The complaints policy incorporates the use of te reo Māori and mentions supports specifically aimed at Māori residents to guarantee an equitable process for them. The operations manager is tasked with ensuring that all complaints are thoroughly documented and investigated. Concerns and complaints are brought up for discussion at appropriate meetings. There were a total of 11 complaints from January 2023 to the audit date. The complaints reviewed evidenced acknowledgement of the lodged complaint within five working days and following investigation, resolution was documented by the operations manager. The Complainants' rights for advocacy and appeal process were also communicated to the complainant. However, documentation did not reflect that complaints management timeframes aligned with the Code.  Complaints were integrated into the quality and risk management system, prompting staff to undergo relevant training. There have been no external complaints received since the previous audit.  Staff members interviewed shared that complaints and subsequent corrective actions are regularly addressed in meetings. Residents and their family/whānau are familiar with the complaint process and expressed comfort in discussing any concerns with both staff and the management team. It was confirmed that relatives had received information about the complaints process. Complaint forms and advocacy service pamphlets are readily available on noticeboards at the facility's entrance. |
| 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 highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve. | FA | Aberleigh Rest Home provides rest home, hospital, dementia, and psychogeriatric level of care for up to 62 residents. On the day of the audit, there were 56 residents.  There are five smaller home environments for residents at Aberleigh Rest Home: Kowhai – a 10 bed rest home and hospital; Ngaio –a 15 bed rest home and hospital; Ngaio -a 10 bed rest home and hospital; Koromiko – an 18-bed dementia home; and Matai – a nine bed psychogeriatric home.  There were 16 rest home residents (including two residents’ under long term support- chronic health contract (LTS-CHC), 18 hospital residents, 15 dementia care (including one under LTS) and 7 psychogeriatric level of care (all under the age-related hospital specialist services contract). The remaining residents were under the age-related residential care contract.  Dementia Care NZ Limited is the parent company under which Aberleigh Rest Home operates. Dementia Care NZ has a corporate structure that includes two managing owner/directors, a team of managers including an operations management leader, quality systems manager, public relations and marketing manager, and strategic communication, engagement and governance advisor, clinical advisor, two regional clinical managers (north and south), and an education coordinator.  The Directors meet with management at a monthly general meeting to discuss the running of the business, key performance metrics and the organisation’s compliance with the relevant policies, procedures, standards and legislation. Clinical and operational risks are discussed at the monthly risk meeting which reports to directors and general meeting. There are terms of reference for responsibilities at the general meeting and for the clinical governance group that reports to the general meeting. Regular quality meetings are held monthly at Aberleigh to raise quality improvements and identify risks and mitigations. Benchmarking between homes is also used to identify risks emerging at particular homes. Risks, issues and outcomes from these local meetings are reported through to the organisational risk meeting if needed and to the general meeting. An organisational risk meeting is held monthly to analyse organisation-wide risks to be reported to the Directors and to rate the severity of the risks and investigate measures to mitigate the risks. Urgent risks are raised with the Directors and responded to immediately as needed.  Dementia Care NZ has a comprehensive strategic plan spanning from 2021 to 2024, coupled with an associated business plan for the years 2022-2023, which is presently undergoing a review process. The insights gathered from this review will contribute to the formulation of the upcoming 2024 Business Plan. The overall business plan includes the vision, values of the organisation and it is documented in English and te reo Māori. On interview, the managing director emphasised the significance of family feedback, which is actively incorporated into the annual service review process.  An interview with the managing director affirmed that the governance body actively monitors key equity metrics, including the count of staff and residents identifying as Māori. Two directors play a role in facilitating connections between iwi and hapu as needed for residents. The Māori Health Plan was signed off by the Dementia Care NZ directors in January 2023 and has a specific focus on advancing cultural care. Ongoing initiatives include strengthening partnerships with local iwi, enhancing staff knowledge and adherence to tikanga, and improving Māori language skills.  The managing director was on site on the second day of the audit, and the audit debrief was given to the clinical advisor and four members of the governance team. The organisation engages with external cultural advisors to work in partnership with Māori to ensure the updating of policy and procedure within the company to enhance the Te Tiriti partnership, reduce inequity, and improve equality. Interviews with the managing director confirmed their commitment to the implementation of their Māori health plan and preventing barriers to achieving health equity. The cultural advisor provides Māori representation at the governance level where required.  The organisation holds an annual training day for all operations and clinical managers. The two-day conference for operations managers was cancelled in 2023 due to Covid- 19 related issues. The site operations manager (non-clinical) has been in the role since 2014 and reports to the operations management leader at head office. The clinical manager has been employed since November 2023 and is supported by the regional clinical manager. |
| Subsection 2.2: Quality and risk  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. | PA Moderate | Dementia Care NZ has a well-established quality and risk management programme, incorporating internal audits, collection of clinical indicator data, and benchmarking with their facilities for performance monitoring. The audit schedule has been implemented; however, corrective actions were not always addressed.  There are monthly quality improvement meetings, health and safety meetings, monthly infection committee meeting, resident event analysis management meetings, activities, clinical meetings, and six-monthly restraint review meetings. Internal audit outcomes including infection control, restraint, complaints, survey outcomes, training, incidents and accidents, and health and safety, are discussed at these meetings. Meeting minutes are available for all staff in the staffroom. Discussions with staff confirmed their involvement in the quality programme.  Annual satisfaction surveys are conducted, and in the 2023 surveys, feedback was gathered from 29 family members. Among the respondents, 79.3% expressed their willingness to recommend the facility to others, while 13.8% maintained a neutral stance. Additionally, 86.2% of participants conveyed contentment with the medical care received and reported feeling well-informed. Operations managers provided instances of incorporating consumer feedback into service improvement initiatives. Staff surveys are also conducted annually, and as of now, the results from the 2023 survey have not yet been analysed.  The incident and accident reports were reviewed. Electronic documentation captures incidents and accidents, with a focus on identifying opportunities to minimise risks. Monthly analysis and collation of incident and accident data take place, and findings are reported during staff through resident incident analysis meetings. These meetings serve as a platform to discuss opportunities for minimising risks.  The service runs a comprehensive Health & Safety programme including policy and training, hazard identification, incident and near miss reporting, and investigations. Health and safety meetings are held monthly. Hazards are documented and addressed appropriately. The hazards were last reviewed in November 2023. Staff have received education related to hazard management and health and safety at orientation and training was offered annually.  Staff meetings took place as scheduled. Meeting minutes are available for all staff. Staff interviews confirmed this.  Discussions with the managing director, the clinical manager, and the operations manager evidenced their awareness of the requirement to notify relevant authorities in relation to essential notifications.  There have been weekly Section 31 reports since the previous audit in relation to RN shortages. In 2023, there was one Section 31 notification completed in relation to a pressure injury. There has been one outbreak documented in 2023 which was appropriately managed and reported to Public Health authorities. |
| 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 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. | PA High | The operations manager and clinical manager (RN) work Monday – Friday. The operations manager is on call for non-clinical matters, and the clinical manager provides on-call after-hours for all clinical matters. When the clinical manager is on leave, a senior RN provides support. The regional clinical manager is available for back-up telephone support. Staff members interviewed expressed satisfaction with the overall staffing levels, noting that the clinical manager offers effective support. Residents and family/whānau interviewed did not raise issues around staff numbers.  Until recently, there was a trained diversional therapist (DT) on site at Aberleigh. Recruitment is ongoing to secure a trained DT for Aberleigh; however, in the meantime, three activities coordinators deliver activates according to the activities plan. There are currently six trained DTs in other DCNZ facilities, one of whom is available to support and oversee activities at Aberleigh. Another four staff members are completing DT training.  There is a 2023 and 2024 training programme which is supported by the national educator. The 2023 training programme was introduced to staff and is technically in place; however, staff attendance has been low across some topics.  Staff have undergone competency assessments for specialised procedures and treatments, encompassing areas such as infection control; restraint; fire safety; hoisting; safe handling; and medication. Medication competencies were not all up to date (link 3.4.3). There were a small number of staff who did not complete other competencies; however, identified gaps have been acknowledged, and ongoing efforts are in progress to address and rectify these deficiencies. Registered nurses are supported to maintain their professional competency.  There are 37 caregivers employed at Aberleigh, and 74.47% of staff have attained the required NZ dementia qualifications. Twenty staff members support the dementia unit and the psychogeriatric unit. Of those, eight staff members have the required qualification, and the remaining 12 have been employed for less than 18 months, and five of them are actively progressing towards achieving this. All caregivers are encouraged to complete the New Zealand Qualification Authority (NZQA) through Careerforce. The cooks have completed the required unit standards.  Staffing is as follows:  Kowhai: (10 dual purpose beds) currently with 10 hospital level of care residents  Morning shift: two caregivers 7 am-3 pm  Afternoon shift: two caregivers - one from 3 pm-11pm and one from 3 pm-8 pm.  Night shift: one caregiver (11 pm to 7 am).  Ngaio home: (15 dual purpose beds) currently with 5 hospital level and 10 rest home residents  Morning shift: three caregivers - one caregiver from 7 am-3 pm, one from 7 am-12.30 pm and one from 8am to 1pm  Afternoon shift: two caregivers - one from 3 pm-11 pm and one from 4.30-9 pm  There is a home assistant on duty from 8 am-1 pm and from 4.45 pm-7.45 pm.  An activities coordinator is rostered from 10am to 4:30pm, seven days a week across Kowhai and Ngaio.  Ngaio extension: (10 dual purpose beds) currently with three hospital residents and six rest home residents.  Morning shift: two caregivers – one from 7 am-3 pm and one from 7 am-12.30 pm  Afternoon shift: two caregivers - one from 3 pm-11 pm and one from 4.30 pm-8.00 pm  Night shift: one caregiver from 11 pm-7 am.  One Activities coordinator 1:30pm to 4:30pm  Matai: (nine psychogeriatric beds) currently with seven residents.  Morning shift: two caregivers – one from 7 am-3 pm and one from 7am to 1pm  Afternoon shift: one caregiver - one from 4:30pm -11 pm and one RN from 3 pm-11 pm  Night shift: one Level 4 IQN (international qualified nurse) caregiver 11pm -7 am  There is one activities coordinator from 1:30 to 4:30pm on duty seven days a week.  Koromiko: (18 bed dementia home) currently 15 residents.  Morning shift: two caregivers from 7 am–3 pm, one home assistant from 7am to 1pm  Afternoon shift: two caregivers from 3 pm-11 pm and one home assistant from 4:30pm to 8pm  Night shift: There is one caregiver on from 11 pm-7 am.  There is an activities coordinator from 10am to 4:30pm seven days a week.  The home assistants compete laundry and cleaning duties. There is a home assistant on night duty who works across all the facility.  There is a cook on duty daily for 9.75 hours and a tea assistant for 2.75 hours.  The clinical manager works Monday- Friday, including two morning shifts in the psychogeriatric unit. Another RN also works a further two morning shifts in the PG unit.  There is one registered nurse on AM and PM duties in the rest home /hospital wings. There is no registered nurse cover on night shifts.  The deficiency in RN coverage has been a consistent issue since the previous audit, the service has not been able to effectively address this ongoing concern. |
| 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. | PA Low | Eight staff files were reviewed (one clinical manager, one activities coordinator, one cook, and five caregivers). Each file had a signed employment contract, job description, police verification, orientation materials, application form, and reference verifications.  An electronic register of RN practising certificates is maintained within the facility. Practising certificates for other health practitioners are also retained to provide evidence of their registration.  All newly employed staff complete a workplace induction prior to commencing their role. Six out of eight files had completed orientation records. Two files were recently employed staff and their orientation continues.  Staff interviewed could describe the orientation process and stated that they believed new staff were adequately orientated to the service.  Annual performance appraisals were not consistently conducted, and an examination of sampled files revealed a lack of appraisals for the past two years. |
| 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 High | Eight electronic resident files were reviewed: two hospital resident files; one rest home file on a long-term support chronic health contract (LTS-CHC); three residents in the psychogeriatric unit; and two in the dementia unit (including one on a LTS-CHC contract). Repetitive non-conformities were found within the minimum sample; therefore, the sample size was increased.  The registered nurses are responsible for all residents’ assessments, care planning and evaluation of care. Contractual requirements related to meeting timeframes were not always met. Documentation did not always reflect that that resident/whānau were involved in the long-term care planning process.  Files reviewed identified that not all residents had a care plan in place. Where care plans were in place, these were not always holistic and individualised to meet the residents’ assessed needs and preferences. Acute changes in health status were not always documented in a short-term care plan or updated in the long-term care plan.  Registered nurses and the clinical manager initiate a review with the nurse practitioner (NP) or GP. The GP/NP input was evident in the files reviewed. Residents have been referred to specialist services when required; however, allied health services input to care was not integrated as part of the care plan. The NP interviewed stated that the staff communicate with the service and that they are informed of concerns in a timely manner. Resident and family/whānau interviewed were grateful for the assistance of the staff and there were no concerns about service delivery raised through the interviews during audit.  Wound charts were completed as required; however, pressure injury prevention and pressure injury management strategies were not sufficiently documented in the long-term care plan (LTCP) in three files reviewed. Neurological observations were recorded by RNs and level four caregivers (international qualified nurses) following all un-witnessed falls. Other monitoring charts were completed to evidence service delivery; however, monitoring requirements identified as part of care interventions were not documented in the care plans.  Progress notes reviewed were reflective of the resident`s journey and include evidence of follow up on advice and instructions and whānau communication. Six-month evaluations were not always completed, LTCPs were not updated following evaluations, and progression towards goals were not documented.  The previous shortfalls related to interRAI assessments and care planning has still not been met and will remain open. |
| 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 High | There are policies and procedures in place for safe medicine management. The service uses an electronic medication management with a robotic roll dispensing system. Medical services are supported by 22 GPs and a NP. Standing orders are not in use. Due to the nature of the service, there were no self-medicating residents on the day of the audit.  This audit identified several issues related to medication management and medication competencies. |
| 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 | A registered dietitian with knowledge and experience in the nutritional needs of elderly people is contracted to provide a nutritious and varied menu; reviewed two yearly. Food preferences and cultural preferences are encompassed into the menu. The kitchen receives resident dietary forms and is notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated, including food allergies. The cook interviewed reported they accommodate residents’ requests.  There is a registered food control plan expiring March 2024, and their verifications audit is due to expire in Aug 2024. There are nutritional snacks available in all units 24/7.  The residents and family/whānau interviewed were complimentary regarding the standard of food provided and the varied options for the residents to choose from |
| 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. We work alongside each person and whānau to provide and coordinate a supported transition of care or support. | FA | Transfer of residents include documentation to ensure all transitions and transfers to and from the service include current needs and risk mitigation. Discharges or transfers were evidence to be coordinated in collaboration with the resident (where appropriate), and family/whānau. Allied health advice /instructions were not always documented as part of the care plans (link 3.2.3). |
| 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. | PA Low | The buildings, plant, and equipment are fit for purpose. The current building warrant of fitness expires 1 July 2024. There is a documented maintenance request process for repairs. Equipment failure or issues are also recorded in the maintenance log. This is checked daily and signed off when repairs have been completed. There is an annual maintenance plan that includes electrical testing and tagging. Clinical equipment is checked for compliance annually; however, not all clinical equipment had a current check completed. Call bell checks and weekly testing of hot water temperatures occur. Essential contractors/tradespeople are available 24 hours a day as required. |
| Subsection 5.2: The infection prevention programme and implementation  The people: I trust my provider is committed to implementing 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. | FA | The infection prevention and control policies reflect the requirements of the standard and are based on current accepted good practice. Policies and the annual infection control plan have been approved by the clinical governance who receive monthly reports around infection control matters. The annual review of the programme is completed by the clinical governance. There are also six-monthly reviews that show their progress towards identified goals.  The infection prevention coordinator is newly appointed to her role, (employed in January 2024) and has not yet completed training related to infection prevention and control; however, this is planned when next available. Previously, the clinical manager has undertaken the role. The infection prevention coordinator was not available on the day of the audit. The clinical manager interviewed described support from expertise within the clinical governance group, public health authorities, microbiologist, and GP’s. The clinical manager will support the infection control coordinator in the role. |
| 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 | The infections surveillance programme is appropriate for the size and complexity of the service. Infection surveillance is linked to the quality and risk management system. Monthly infection data is collected for all infections based on signs, symptoms, and definitions of infection. Infections are entered into an electronic infection register. Surveillance of all infections is collated into a monthly infection summary. This data is monitored and analysed for trends monthly and annually. This data is reported back to the Dementia Care NZ office and used for internal benchmarking. Infection control surveillance is discussed at the integrated quality improvement/staff meetings and infection control meetings. The service captures ethnicity data for Māori.  There has been one Covid-19 outbreak in 2023. The outbreak was contained in one of the wings and was managed well. |
| 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 | Aberleigh is committed to providing services to residents without the use of restraint. The restraint coordinator is the clinical manager. The use of restraint is communicated to the Directors through a monthly clinical report from clinical governance. Incidents involving the use of restraint are escalated to the Directors through the established process as required.  Restraint practices are relevant to individual resident requirements and the least restrictive options are used first. Restraints are only used where it is clinically indicated, justified and other strategies, including falls prevention interventions, have been demonstrated to be ineffective.  At the time of the audit there no residents using restraints. Restraint documentation processes are documented in the restraint minimisation elimination and safe practice policy and include assessments, consent, monitoring, and evaluation processes to minimise associated risks. When in use, quality review of restraint use occurs monthly and is benchmarked. The use of restraint is reported in the quality management, registered nurse, and staff meetings. Training for all staff occurs at orientation and annually as sighted in the training records. Staff have completed training related to restraint and include Best Friend approach, and de-escalation of behaviours that challenge. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.8.3  My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers’ Rights. | PA Low | There was a total of 11 complaints from January 2023 to the audit date. Both managers are tasked with ensuring that all complaints are thoroughly documented and investigated. During periods when a clinical manager was not present, the regional clinical manager was assisting in investigating clinical issues. Concerns and complaints are brought up for discussion at appropriate meetings. The complaints reviewed evidenced acknowledgement of the lodged complaint within five working days and following investigation, resolution was documented by the operations manager. There are two complaints that were raised in December 2023 in regard to care-related issues that remain open. | Complaints that exceeded the timelines of 10 and 20 days necessitate an update for the complainant. Two complaints, classified as clinical, extended over a period of three months without any recorded progress reporting and or updates provided to the complainant. The resolution of these clinical complaints falls under the management of governance. Advised that the complainants were contacted around the extended investigation time. However, this was not appropriately documented. | Ensure that complaints are documented as managed according to the Code and documentation reflects that the complainant is informed if complaint investigation exceeds 20 days.  90 days |
| Criterion 2.2.3  Service providers shall evaluate progress against quality outcomes. | PA Moderate | The implementation of the quality and risk management programme is undertaken by the operations manager and the clinical manager. The reported quality data encompasses falls, behavioural incidents, bruises, pressure injuries, skin tears, infections, medication errors, and restraint use. This data is compiled for benchmarking, and the results are communicated back to the facility for potential inclusion in quality improvement plans if deemed necessary. The audit schedule has been implemented and corrective actions concerning non-clinical audits have been identified and actioned; however, clinical file internal audits did not include corrective actions and evidence of follow up. | A review of clinical file internal audits identified that audits completed (October 2023 and November 2023) had an outcome of 72% and 52%. Corrective actions were not established where shortfalls were identified around care plan interventions and assessments. | Ensure that corrective actions required from the clinical file audits are developed and actioned.  90 days |
| 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 | There are three full-time RNs and two casual RNs. At the time of the audit one of the RNs was on annual leave. The clinical manager assumed her role in November 2023 after successfully completing her RN CAP (Competence Assessment Programme) programme. The clinical manager is currently scheduled for RN shifts twice a week. The operations manager indicated that there are at least two full-time equivalent RN vacancies. Currently, there are two RN CAP students undergoing their programme, and the service anticipates employing them upon their registration with the Nursing Council.  Following the onsite audit, the service has put in place corrective actions. The funder has agreed the service has mitigated the risk for the following reasons. (i)The service has two additional RNs who have completed their CAP programme and are awaiting NCNZ Registration. These RNs will commence interRAI training as soon as their APC is available. (ii).There are two casual RNs who cover 35 RN shift per week. (iii).There has been an influx of additional (temporary) staff to assist in completing assessments and care plans to get them all up to date. (iv).Two RNs are enrolled to commence interRAI training in February 2024. | (i) There is a registered nurse based across the hospital/rest home units in the morning and afternoon shifts; however, there is no RN on night duties at the facility from 11pm to 7am. The service does not meet the staffing requirements of the Age-Related Residential Care Services Agreement (ARCC) D17.4 i. The clinical manager is on call seven days a week to manage clinical emergencies. In the psychogeriatric unit, there is one RN for two morning shifts a week, and the clinical manager is rostered for another two days in a registered nurse role. There is no registered nurse rostered in the afternoon or night shifts across the week. Level 4 IQN (international qualified nurse) caregivers have been rostered to oversee the medication and clinical care. The service does not meet the staffing requirements of the Age-Related Hospital Specialised Services Agreement ARHSS D17.3 (b). There is a lack of registered nurse coverage since the previous audit. The operations manager has communicated the challenge of being unable to cover night duties over a year. There are weekly Section 31 notifications to HealthCERT.  (ii) The clinical manager is the only interRAI-trained RN. Currently, one RN is undertaking the interRAI training. Consequently, interRAI assessments are not up to date (also refer 3.2.1). | (i) and (ii) Ensure 24/7 RN cover to meet the requirements of the ARRC and ARHSS agreements. (ii). Ensure sufficient interRAI qualified RNs to undertake interRAI assessments in a timely manner.  30 days |
| 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 Low | There is a 2023 and 2024 training programme which is supported by the national educator. The 2023 training programme was introduced to staff and is technically in place; however, there has been limited staff participation in certain subjects. While attendance lists for training sessions exist, these sessions typically lasted between 30 to 45 minutes each. Special focus has been given to palliative care training, best friend models of care training, and dementia-specific training, with multiple offerings throughout the year; all of which had a high level of attendance. Staff first aid certificates were recently updated. | The 2023 training programme was introduced to staff and is technically in place; however, there has been limited staff participation in certain subjects. Example (but not limited to): only four attended infection control and Falls management, and two attended abuse & neglect. | Ensure staff not attending mandatory training sessions are followed.  180 days |
| Criterion 2.4.5  Health care and support workers shall have the opportunity to discuss and review performance at defined intervals. | PA Low | Annual performance appraisals were not completed consistently. | Eight staff files were reviewed (one clinical manager, one activities coordinator, one cook, and five caregivers). Among these, two staff members had been employed for less than a year and were not yet due for performance evaluations. Of the remaining six, only one had an up-to-date performance appraisal, while the performance appraisals in the other files were last conducted in 2021. | Ensure that annual staff appraisals are completed.  180 days |
| Criterion 3.2.1  Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this. | PA Moderate | Eight files were reviewed. Contractual requirements in relation to timeframes of care plan documentation has not been met. The sample was widened due to non-conformities within the minimum sample. The registered nurses (RN) are responsible for all residents’ assessments, care planning and evaluation of care. The RNs interviewed were relatively inexperienced and new to NZ but have a good understanding of contractual requirements (also refer 2.3.1). Documentation did not always evidence that whānau /resident were consulted or involved in the assessment and care plan development.  Since the onsite audit, the service has provided evidence to the Funder that the interRAI assessments and care plans reviewed at audit have been updated and completed on 9 February 2024. | (i) Timeframes related to contractual requirements were not always met in the eight the files reviewed and include: a) Four residents (one rest home, two PG, one hospital) did not have a care plan documented within 21 days of admission or thereafter; b) Two PG residents had no initial interRAI completed. They were admitted in August 2023 and still do not have an interRAI. One resident from the dementia unit was overdue for an interRAI reassessment; c) One resident in the dementia unit had no interim care plan completed within 24 hours of admission or thereafter; d) Three residents (two dementia and one PG) with care plans were overdue for their six-month evaluations (overdue three weeks to 18 months).  (ii). There was no documented evidence that resident/whānau were involved in the long-term care planning process in five of eight files (one hospital, two dementia level (including LTS-CHC) and two PG). | (i). Ensure assessment and care planning processes align with any contractual requirements and include individual goal setting.  (ii) Ensure documentation reflects evidence of whānau/resident input.  60 days |
| Criterion 3.2.3  Fundamental to the development of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people’s lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people’s values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a person’s wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People’s care or support plan identifies wider service integration as required. | PA High | The registered nurses are responsible for the development of the care plan. Assessment tools including cultural assessments were not always completed to identify key risk areas.  Alerts are indicated on the resident` profile and include (but not limited to) high falls risk; allergies; weight loss; behaviour; swallowing difficulties; resuscitation status; and pressure injury risks.  Not all clinical files reviewed evidenced care plan documentation was completed, including the interventions required for each resident. Information is documented within progress notes, documented incidents, handover during shift, utilising of STCP and monitoring charts (worklogs), to evidence care delivery.  Caregivers are knowledgeable about the care needs of the residents and the families/whanau interviewed provide positive comments related to the care experience.  Since the onsite audit, the service has provided evidence to the Funder that the interRAI assessments and care plans reviewed at audit have been updated and completed on 9 February 2024. | (i) Other assessment tools including cultural assessments and interRAI assessments were not consistently completed to identify key risk areas and to inform the care plan in all files reviewed.  (ii) Care plans were not always developed and/or insufficient to specifically guide care for; a) falls management; b) Three of three residents with pressure injuries did not have documentation completed as required; c) behaviour management; d) mobility/transfer assistance and e) oral health.  (iii) Allied health advice /instructions were not documented as part of the care plans. | (i) Ensure risk assessment tools are used to inform care planning and when changes occur.  (ii)-(iii) Ensure there is an up-to-date care plan in place that provides sufficient strategies to guide staff in caring for the resident.  7 days |
| Criterion 3.2.4  In implementing care or support plans, service providers shall demonstrate: (a) Active involvement with the person receiving services and whānau; (b) That the provision of service is consistent with, and contributes to, meeting the person’s assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective; (c) That the person receives services that remove stigma and promote acceptance and inclusion; (d) That needs and risk assessments are an ongoing process and that any changes are documented. | PA Moderate | Registered nurses create worklogs with required frequencies to ensure service delivery; these were diligently completed by staff and include weight recordings; blood pressure and vital signs; food and fluid charts; bowel charts; reposition charts; sleep charts; behaviour monitoring; intentional rounding/checks; toileting; and three-day continence charts. However, the required monitoring for service delivery was not always documented in the care plans. Registered nurses review monitoring charts as part of daily reviews; however, there was no evidence that the behaviour monitoring charts were regularly reviewed, and de-escalation techniques added to the LTCP.  Short-term care plans (STCP) were utilised and are implemented to deliver care in the files reviewed; however, not all acute changes in health status had a STCP in place or updated in the LTCP. Where STCPs were utilised in the files reviewed, these were signed off as resolved. Where acute changes in health status remained ongoing, these were not added to the long-term care plan, and all health changes that were documented in the progress notes were not always evident in a care plan. | i) Where monitoring of care delivery is required, the requirements were not documented in the care plans: a) fluid monitoring for one PG resident with recurrent UTI; b) pressure relief and repositioning for one PG resident; c) bowel monitoring for one rest home resident; d). food chart for unplanned weight loss for one hospital level resident; e) toileting chart for one resident in the PG unit with recurrent falls.  (ii). There was no evidence that behaviour monitoring charts were being regularly reviewed or de-escalation strategies added to the long-term care plan in three PG, one rest home, and two dementia files reviewed.  (iii) STCPs were utilised in the files reviewed; however, a) not all acute changes in health status identified in the progress notes had interventions documented in a STCP or added to the LTCP completed; and b) where acute changes in health status remained ongoing, these were not added to the long-term care plan. | (i) Ensure monitoring requirements as part of service delivery are documented in a care plan.  (ii) Ensure behaviour charts are reviewed and de-escalation strategies and triggers are documented in the care plan.  (iii) Ensure where acute changes in health status are identified that; a) that interventions are documented in a STCP or the LTCP updated; and b) when health issues become ongoing, that interventions are incorporated in the LTCP.  30 days |
| 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 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. | PA Moderate | Registered nurses are responsible for care plan evaluations; however, not all care plans were evaluated or updated as healthcare needs change or progression towards goals were not documented. Changes are communicated to staff via handovers, noticeboard on the electronic system and progress notes. | (i) Care plans and risk assessments were not updated following health changes identified through the care plan evaluation in four files reviewed (one hospital, two dementia, one PG).  (ii) There was lack of documented evidence that care evaluations identify progress towards meeting goals in the same four files reviewed. | (i) Ensure risk assessments and care plans are updated following changes in health status.  (ii) Ensure evaluations when it occurs identify progress towards meeting the goals.  60 days |
| Criterion 3.4.1  A medication management system shall be implemented appropriate to the scope of the service. | PA High | There are policies and procedures in place for safe medicine management. The service uses a robotic roll dispensing system, and medicines are delivered on a monthly basis in two weekly rolls. Medication errors are reported, and those sighted evidence corrective action follow-up which were reported to the staff. This was evidenced in the meeting minutes. The GP/ NP have reviewed the medication charts at least three-monthly. The effectiveness of ‘as required’ medication had been documented in the medication system. Controlled drugs are administered as prescribed. Weekly and six-monthly stocktakes are completed.  Any discrepancies related to pharmacy errors are fed back to the supplying pharmacy. Expired medications are documented and returned to the pharmacy. There is one medication room for the facility. The medication fridge temperatures and room air temperature are checked daily and recorded. Temperatures have been maintained within the acceptable temperature range.  Thirteen electronic medication charts were reviewed, and auditors identified the following shortfalls. Aberleigh home is served by 22 GPs and advised that not all use the electronic patient management system. Communication between these GPs and the service primarily occurs through emails and phone calls. The clinical manager is applying considerable effort into effectively managing communication with the GPs. The home has been experiencing a shortage of registered nurses (RNs) since the previous audit (link 2.3.1). Syringe driver training is scheduled for February 2024.  Three residents require daily insulin administration, but there is currently no Gluco-Hypo Kit (or similar) available. In the absence of adequate RN coverage, auditors strongly advocate that such kits be provided to manage potential hypoglycaemia events. This was purchased by the service following the onsite audit.  Since the onsite audit, the service has provided evidence to the Funder that the medication shortfalls have been addressed on 9 February 2024. | (i) A resident prescribed anticoagulant medication necessitates a monthly INR test, but the test has not been conducted within the past 18 days, which exceeds the recommended monthly interval. This was alerted by the auditors.  (ii). A resident who has received more than 40 doses of quetiapine since being admitted to the service in October 2023. This resident also does not have a documented care plan in place. The initial medical admission was conducted by the GP, and the clinical manager reported that the GP has seen the resident in early January. However, there were no records indicating the GP's review of the resident's use of PRN drugs or any documentation of a medical review. There is an absence of both long-term and short-term care plans to address behaviour modification or the use of antipsychotic drugs (link 3.2.4).  (iii). A resident has been prescribed clonazepam drops for anxiety and agitation on an ‘as required’ (PRN) basis. This has been administered 20 times since 17 November 23. There is a lack of GP review, an absence of RN input in the resident's care, and an absence of a long-term care plan to address behavioural concerns or anxiety (link 3.2.4). The oversight and communication with the GP and OPMH team was not always documented as required.  (iv) Three residents require daily insulin administration, but there is currently no Gluco-Hypo Kit (or similar) available in the event of severe hypoglycaemia. This was purchased by the service after the audit. | (i). Ensure that medicines are managed as prescribed by the GP and follow up tests to manage dosage is undertaken. (ii)-(iii) Conduct a thorough review of current practices related to medication management. Ensure that PRN medication administration is monitored by the RNs and GP, and input regarding use of antipsychotics drugs are obtained and documented. Ensure that oversight and communication with the GP and OPMH team is documented. (iv) Ensure a Gluco-Hypo Kit (or similar) is available in an emergency.  7 days |
| Criterion 3.4.3  Service providers ensure competent health care and support workers manage medication including: receiving, storage, administration, monitoring, safe disposal, or returning to pharmacy. | PA High | Medicines are administered by the level 4 qualified caregivers and RNs. At the time of the audit, not all medication competent staff had completed annual medication competency assessments. Medications are checked in by Level 4 IQN (international qualified nurse) caregivers on arrival.  Since the onsite audit, the service has provided evidence to the Funder that the medication competencies are up to date on 9 February 2024. | There are 20 staff who are listed as medicine-competent and nine of them did not have current medication competencies. One staff member who works in the psychogeriatric unit and rostered to administer medications has not had an updated medication competency since 2022. | Ensure that staff who administer medication maintain current medicine competency.  7 days |
| Criterion 4.1.1  Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples’ cultures and supports cultural practices. | PA Low | The operations manager is responsible for the implementation of the annual maintenance schedule. Medical assets/equipment has been tested/calibrated in March and May 2023; some clinical equipment was overdue. | One oxygen concentrator and one suctioning equipment have not been tested since 2022. | Ensure all equipment is included in the annual testing and calibration schedule.  90 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 audit.

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End of the report.