

The Grange Care Limited - The Grange

Introduction

This report records the results of a Certification 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](#).

The specifics of this audit included:

Legal entity: The Grange Care Limited

Premises audited: The Grange

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

Dates of audit: Start date: 9 May 2024 End date: 10 May 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: 18

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 haumarū | 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 |
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|  | 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 |
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| | 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

The Grange provides rest home and hospital services for up to 20 residents, there were 18 residents on the days of the audit.

This certification audit was conducted against the relevant Ngā Paerewa Health and Disability Services Standard 2021 and funding agreements with Health New Zealand Te Whatu Ora - Southern. The audit processes included observations, a review of organisational documents and records, including staff records and the files of residents, interviews with residents and their family/whānau, and interviews with the general practitioner, staff, and management.

The clinical care manager at The Grange has experience in aged care management. The clinical care manager is supported by the organisations chief executive officer, who also oversees a sister facility. Residents and family/whānau reported satisfaction and positivity about the care, services, and activities provided.

This certification audit identified an area requiring improvements regarding informed consent, clinical governance, implementation of the quality programme, staff appraisals, care planning, medication management, first aid certificates, aspects of infection control and restraint.

Ō tātou motika | Our rights

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| <p>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.</p> | | <p>Some subsections applicable to this service partially attained and of low risk.</p> |
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The service works collaboratively to support and encourage te ao in service delivery. Māori are provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake. Pacific peoples are provided with services that recognise their worldviews and are culturally safe.

Residents and their family/whānau are informed of their rights according to the Code of Health and Disability Services Consumers' Rights and these were being upheld. Personal identity, independence, privacy, and dignity were respected and supported. Processes were in place to protect residents from abuse.

Residents and family/whānau receive information in an easy-to-understand format that enables them to feel listened to and make decisions about care and treatment. Open communication is practiced. Interpreter services were provided as needed. Family/whānau and legal representatives were involved in decision making that complies with the law. Advance directives were being followed wherever possible.

Complaints are resolved promptly and effectively in collaboration with all parties involved.

Hunga mahi me te hanganga | Workforce and structure

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| <p>Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.</p> | | <p>Some subsections applicable to this service partially attained and of low risk.</p> |
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The clinical care manager is supported by registered nurses, the chief executive, and the owners/directors. Governance is committed to improving pae ora outcomes and achieving equity. The needs of residents are considered. Management and the owners/directors have knowledge and expertise in Te Tiriti o Waitangi, health equity, and cultural safety.

The business plan includes a mission statement and outlines current objectives. The plan is supported by quality and risk management processes that take a risk-based approach.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practices. An orientation programme is in place for new staff. An education and training plan is implemented. Competencies are defined and monitored. Staff records are secure and staff ethnicity data is collected.

Ngā huarahi ki te oranga | Pathways to wellbeing

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| <p>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.</p> | | <p>Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. Registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

The diversional therapist and activities coordinator provide and implement an interesting and varied activity programme which includes resident-led activities and meets the needs of individual residents. The programme includes outings, entertainment and meaningful activities that meet the individual recreational preferences.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior healthcare assistants responsible for administration of medicines complete annual education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The service has a current food control plan.

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

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| <p>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.</p> | | <p>Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. All rooms have an ensuite and a kitchenette area. There are communal shower rooms with privacy signs. Rooms are personalised. Documented systems are in place for essential, emergency and security services.

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

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| <p>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.</p> | | <p>Some subsections applicable to this service partially attained and of low risk.</p> |
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The service ensures the safety of residents and staff through a planned infection prevention and control and antimicrobial stewardship programme that is appropriate to the size and complexity of the service. The clinical care manager coordinates the programme.

There are sufficient infection prevention and control resources, including personal protective equipment available and readily accessible to support this plan if it is activated.

Surveillance of healthcare associated infections is undertaken. Follow-up action is taken as and when required. There were no outbreaks recorded since the service opened.

The environment supports the prevention of transmission of infections. The environment, and facility were clean, warm, and welcoming. Waste and hazardous substances are well managed. There are safe and effective laundry services.

Here taratahi | Restraint and seclusion

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| <p>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.</p> | | <p>Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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The restraint coordinator is the clinical care manager. Restraints are in use at The Grange. Staff complete restraint minimisation education.

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) |
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| Subsection | 0 | 19 | 0 | 5 | 5 | 0 | 0 |
| Criteria | 0 | 161 | 0 | 7 | 8 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
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| 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](#).

For more information on the different types of audits and what they cover please click [here](#).

| Subsection with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>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.</p> | <p>FA</p> | <p>A Māori Health Plan is documented for the service. This policy acknowledges Te Tiriti o Waitangi as the founding document for New Zealand, with guidelines providing a framework for the delivery of care. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in te reo Māori and English.</p> <p>There were no residents who identify as Māori on the days of the audit. The Māori Health Plan identifies specific cultural interventions around food, cares, and practices as per policy and tikanga guidelines. The clinical care manager interviewed stated that cultural needs are met, and the service supports them to link with family/whānau if required. The chief executive works in partnership with iwi and through their extensive connections with Māori organisations within and beyond the health sector is working to ensure better service integration, planning, and support for Māori. Further to this one of the owners/directors identifies as Māori.</p> <p>Interviews with the clinical care manager and ten staff (four healthcare assistants, one head chef, two registered nurses (RN), two housekeepers, and activities coordinator) described cultural support as per the policy and the care plans reviewed evidenced a</p> |

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| | | <p>Māori-centred approach. The interviewed staff members further confirmed culturally safe support is provided to residents and that mana is respected.</p> <p>Ethnicity data is gathered when staff are employed. The Grange do not currently have any staff who identify as Māori. The Māori Health plan support strategies to increase Māori capacity by employing and recruiting Māori staff at The Grange. The chief executive and clinical care manager confirmed their commitment to increase Māori capacity by employing Māori staff members across different levels of the organisation, as vacancies and applications for employment permit. Staff members interviewed stated that they are supported in a culturally safe way and staff are encouraged to use both te reo Māori and relevant tikanga in their work with the residents, as detailed in the Māori health plan and tikanga guidelines.</p> |
| <p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p> <p>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.</p> <p>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.</p> | <p>FA</p> | <p>The Grange recognises the uniqueness of Pacific cultures and the importance of recognising that dignity and the sacredness of life are integral in the service delivery of Health and Disability Services for Pacific people. A comprehensive Pacific health plan has been developed by an external consultant in collaboration with Pasifika. The policy is based on the Ministry of Health Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025. The Code of Residents Rights are available in different languages according to resident need.</p> <p>On the day of audit there were no Pacific residents living at The Grange. The clinical care manager confirmed the availability of local Pasifika health agencies who would support staff if there were Pasifika residents who came to The Grange. Family/whānau are encouraged to be present during the admission process and the service welcomes input from the resident and family/whānau in service delivery. Individual cultural beliefs are documented in the activities profile, activities plan and care plan.</p> <p>At the time of the audit, The Grange had no staff who identified as Pasifika and is not currently recruiting new staff. The clinical care manager confirmed they would encourage and support any future</p> |

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| | | <p>staff that identified as Pasifika, beginning at the employment process.</p> <p>Interviews with staff members, two hospital level residents, and three family/whānau (hospital) identified that the service puts people using the services, family/whānau, and The Grange community at the heart of their services.</p> |
| <p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p> | FA | <p>The Grange staff understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents following their wishes. The family/whānau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service and confirmed they were provided with opportunities to discuss and clarify their rights. The Code is available in te reo Māori, English and other languages are available if required.</p> <p>The chief executive reported the service recognises Māori mana motuhake (self-determination) of residents, family/whānau, or their representatives by involving them in the care delivery process to determine residents' wishes and support needs. There are cultural policies which outline tikanga best practice guidelines to follow.</p> |
| <p>Subsection 1.4: I am treated with respect</p> <p>The People: I can be who I am when I am treated with dignity and respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake.</p> <p>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.</p> | FA | <p>Residents are supported in a way that is inclusive and respects their identity and experiences. Family/whānau and residents confirmed that they receive services in a manner that has regard for their dignity, gender, privacy, sexual orientation, spirituality, choices, and characteristics. Residents' files sampled confirmed that each resident's individual cultural, religious, social needs, values, and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>The clinical care manager reported residents are supported to maintain their independence by staff through daily activities. Residents were able to move freely within and outside the facility's secure spacious garden area.</p> |

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| | | <p>There is a documented privacy policy that references current legislation requirements. The service uses door cards to ensure privacy is maintained during personal cares and these along with staff knocking on the doors before entering were observed.</p> <p>All staff have completed cultural training as part of orientation, and this is scheduled annually. The clinical care manager reported the activities coordinator is working with staff, residents, and family/whanau to promote te reo Māori and tikanga Māori practices which are promoted, this includes policy translation of English words to te reo Māori. Te reo Māori is celebrated and opportunities are created for residents and staff to participate in te ao Māori. Tāngata whaikaha needs are responded to as assessed.</p> |
| <p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p> | <p>FA</p> | <p>The staff code of conduct is discussed and signed during the new employee's induction to the service, with evidence of staff signing the code of conduct policy. This code of conduct policy addresses the elimination of discrimination, harassment, and bullying. Staff are held responsible for creating a positive, inclusive, and a safe working environment and are encouraged to address issues of racism and to recognise own bias.</p> <p>Staff complete education during orientation and annually as per the training plan on how to identify abuse and neglect. Further to this staff are educated on how to value residents, showing them respect and dignity. Family/whānau interviewed confirmed that staff are caring, supportive, and respectful.</p> <p>Police checks are completed as part of the employment process. The service implements a process to manage residents' comfort funds, such as sundry expenses. Professional boundaries are defined in job descriptions and are covered as part of orientation. The staff members interviewed confirmed their understanding of professional boundaries, including the boundaries of their roles and responsibilities.</p> <p>The service promotes a community living, holistic model of care to ensure wellbeing outcomes for their Māori residents is prioritised. Healthcare assistants interviewed confirmed their understanding of</p> |

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| | | holistic care for all residents. |
| <p>Subsection 1.6: Effective communication occurs</p> <p>The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing.</p> <p>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.</p> <p>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.</p> | FA | <p>Policies and procedures relating to accident/incidents, complaints, and open disclosure policy alert staff to their responsibility to notify family/whānau of any accident/incident that occurs. All communication with families regarding incidents/ accidents is documented on adverse event forms and is also documented in the progress notes. The adverse event forms reviewed identified family/whānau are kept informed, and this was confirmed through the interviews with family/whānau.</p> <p>An interpreter policy and contact details of interpreters are available. Interpreter services are used where indicated. At the time of the audit, all residents could speak and understand English. Healthcare assistants and the RNs interviewed described how they would be able to assist residents that are unable to communicate or do not speak English, with interpreters or resources to communicate as the need arises.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family/whānau are informed prior to entry of the scope of services and any items that are not covered by the agreement.</p> <p>The service communicates with other agencies that are involved with the resident, such as Hospice and Health New Zealand specialist services (eg, physiotherapist, clinical nurse specialist for wound care, older adult mental health service, speech language therapist and dietitian). The delivery of care includes input from members of the multidisciplinary team. The clinical care manager described an implemented process around providing residents with time for discussion around care, time to consider decisions, and opportunity for further discussion, if required.</p> |
| Subsection 1.7: I am informed and able to make choices | PA Low | Five resident files reviewed included appropriately signed resuscitation plans and advance directives in place. An advance |

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| <p>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.</p> <p>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.</p> <p>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.</p> | | <p>directive policy is in place. Discussions with family/whānau demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been signed and sighted for all the files seen. Copies of enduring power of attorneys (EPOAs) were included in resident files reviewed.</p> <p>There are policies around informed consent; however, files did not evidence signed general consent forms. Residents and family/whānau interviewed could describe what informed consent was and knew they had the right to choose. Resident files reviewed evidenced signed Covid - 19 and influenza vaccination consent forms.</p> |
| <p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>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.</p> <p>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.</p> | <p>FA</p> | <p>A complaints register is in place. A feedback form is available at the front desk for anyone to provide compliments or raise concerns. Discussions with residents, and family/whānau confirmed they are provided with information on the complaints process. Family/whānau remarked that all concerns or issues raised, are addressed promptly by the clinical care manager and the chief executive.</p> <p>There has been one complaint recorded since opening (April 2024). The complaint is recent and timeframes for managing this complaint have been met. This complaint has been fully investigated. The chief executive has sent the final letter to the complainant (family member) and is awaiting their response prior to closing out the complaint. The chief executive confirms that complaints, both verbal and written complaints are managed in line with the guidelines set by the Health and Disability Commissioner. The chief executive confirmed that service improvement measures would be taken from complaints investigations and would be implemented, as necessary.</p> <p>Family/whānau and residents making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. The Code of Health and Disability Services Consumers' Rights is visible, and available in te reo Māori, and English. Residents and family/whānau interviewed were able to describe managing a complaint that includes being able to raise these when needed, or directly</p> |

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| | | approaching the staff or management team. |
| <p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>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.</p> <p>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.</p> | PA Low | <p>The Grange Retirement Home & Hospital Limited operates as The Grange and is certified to provide rest home, and hospital (medical and geriatric) levels care for up to 20 residents. On the day of audit there was a total of 18 residents (nine rest home and nine hospital). All residents were on the age related residential care (ARRC) contract. All rooms have occupational right agreements in place, and all are certified as dual purpose.</p> <p>The service is managed by an experienced registered nurse and has been in the current role since August 2023. Prior to this role, they were employed in clinical management roles. The clinical care manager has enrolled in upcoming further professional development related to managing a rest home/hospital.</p> <p>The owners/directors and shareholders are the governing body of The Grange. The owners/directors are very experienced, having been involved in the development of other villages over the past 30 years (including hospitals and rest homes). At The Grange and its' sister facility they have ensured compliance with legislative, contractual, and regulatory requirements with demonstrated commitment to international conventions. The chief executive stated that since opening they have just begun to implement the quality plan and process as the strategic execution plan is the key document outlining objectives 2023 – 2026. The strategic execution plan includes a mission statement, scope, direction, goals, values, and operational objectives. The chief executive provides a monthly report to the owners/directors and these showed information monitoring performance including potential risks, contracts, human resource and staffing, ethnicity related to incidents and infections, growth and development, maintenance, and financial performance. The 2023 objectives have been reviewed and signed off as fully attained; however, the owners/directors have not signed off the quality plan which includes infection prevention and control and restraint management. The Grange's clinical governance structure will be supported by the clinical care manager; however, this structure has not yet been implemented as the clinical care manager</p> |

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| | | <p>does not attend the Board meetings.</p> <p>The clinical care manager and chief executive are in daily communication, this is face to face daily when the chief executive is at The Grange and by phone when not on site (alternate weeks). The chief executive attends staff meetings when they are held.</p> <p>One of the owners/directors identifies as Māori and provides Māori representation informing organisational operational processes. At interview, the chief executive confirms there are plans to collaborate with mana whenua through community agencies in business planning and service development to improve outcomes and achieve equity for Māori; to identify and address barriers for Māori for equitable service delivery. The chief executive described how residents have experienced improved health outcomes while in the service, and how this evidenced equity for tāngata whaikaha people with disabilities. This was corroborated in interviews with family/whānau. The owners/directors and the chief executive have completed training in Te Tiriti o Waitangi, health equity, and cultural safety.</p> |
| <p>Subsection 2.2: Quality and risk</p> <p>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.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>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.</p> | <p>PA Low</p> | <p>Policies and procedures and associated implementation systems provide assurance that the facility is meeting good practice and adhering to relevant standards. A document control system is in place. Policies have been implemented and new policies or changes to policy are communicated to staff. Since opening, the facility has been working toward implementing the quality and risk management programme which includes performance monitoring and benchmarking through internal audits, collection, collation, benchmarking of clinical indicator data. This process has been slow to be implemented with the internal auditing process commenced in March 2024. The eight audits that have been completed have not been reported through to staff meetings, and the results were not evidenced as shared with staff.</p> <p>Staff meetings have been planned to take place every two months; it is intended that the staff meeting will include quality data and results. The clinical care manager has started to attend the quality meetings</p> |

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| | <p>held at the sister facility, and it is intended this will be a combined meeting via zoom. The staff meetings that have been held have provided an avenue for discussions in relation to (but not limited to) health and safety, infection prevention and control/pandemic strategies, complaints received, staffing, and education; there is a planned monthly to two monthly clinical meeting; however, these meetings have not always been held according to schedule.</p> <p>A planned annual staff, resident and family/whānau satisfaction surveys is scheduled for June 2024. There have been no resident meetings held; however, family/whānau interviewed confirmed there has been adequate family/whānau interaction and one on one meetings.</p> <p>Health and safety has been included in the staff meetings. New health and safety representatives are being trained. Manufacturer safety data sheets are up to date. Hazard identification forms and an up-to-date hazard register was reviewed in March 2024 (sighted). Health and safety policies are implemented and monitored by the chief executive. A staff noticeboard keeps staff informed on health and safety. Staff and external contractors are orientated to the health and safety programme. Manual handling training sessions have been held for staff. In the event of a staff accident or incident, a debrief process is documented on the adverse event form. Wellbeing programmes include offering employees external support by an employee assistance programme.</p> <p>The clinical care manager reviews every adverse event. In the two months where staff meetings were held adverse events, including infections and incident and accident data was collated and shared with staff. Quality data is available to the chief executive through the electronic system and is utilised to benchmark with the sister facility. Twelve adverse event forms were reviewed (witnessed and unwitnessed falls, bruises, and skin tears) and family/whānau were notified following adverse events, this was confirmed in interviews; however, the follow-up action(s) required were not well documented and described. The opportunities to minimise future risks were neither identified by the clinical care manager nor recorded in the care plan when acute changes occurred.</p> <p>All staff have completed cultural safety training to ensure a high-</p> |
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| | | <p>quality service is provided for Māori. Positive outcomes for Māori and people with disabilities are part of quality and risk activities. The clinical care manager reported that high-quality care for Māori would be achieved by using and understanding Māori models of care, health and wellbeing, and culturally competent staff.</p> <p>Discussions with the clinical care manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been no Section 31 notifications required.</p> |
| <p>Subsection 2.3: Service management</p> <p>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.</p> | <p>FA</p> | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. Healthcare assistants reported there were adequate staff to complete the work allocated to them. The last three weeks roster confirms that there is a RN on shift 24/7. The resident and family/whānau interviewed supported this.</p> <p>The clinical care manager currently works 40 hours a week Monday to Friday and is available on-call 24/7. The clinical care manager and most RNs had a current first aid certificate; however, there were shifts where there was no members of staff with a current first aid certificate (link 4.2.4). The service continues to recruit RNs.</p> <p>Continuing education is planned at orientation and on an annual basis, including mandatory training requirements. Evidence of regular education provided to staff was sighted in attendance records. The training topics on the in-service calendar included (but are not limited to) infection control /hand hygiene, outbreak management, moving and handling, safe food handling, complaints, resident's Code of Rights, managing continence, cultural safety, Tiriti o Waitangi, challenging behaviour, and medication management. Related competencies are completed as required for RNs including interRAI, syringe driver competency, and controlled drug competency. Further training for RNs includes (but is not limited to), palliative care, pressure injury prevention, and management coordination.</p> |

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| | | <p>Healthcare assistants are supported to complete a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's funding and service agreement. There are eleven healthcare assistants (HCAs), one has a level 5 qualification, five HCAs have achieved level 3 and above; one who has completed level 2 NZQA qualifications.</p> <p>Staff records reviewed demonstrated completion of the required training and competency assessments. Each of the staff members interviewed reported feeling well supported and safe in the workplace. The ethnic origin of each staff member is documented on their personnel records and used in line with health information standards. The clinical care manager reported The Grange model of care ensured that all residents are treated equitably.</p> <p>The service has an environment that encourages collecting and sharing quality Māori health information. The service has a relationship with Māori organisations who provide the necessary clinical guidance and decision-making tools that are focused on achieving healthy equity for Māori. At the time of the audit, the service had no staff and residents who identified as Māori. Staff wellness is encouraged through participation in health and wellbeing activities, with staff being asked for suggestions for this.</p> <p>There are six RNs including the clinical care manager. The clinical care manager is interRAI trained with a RN in training and other RNs enrolled. The staff records sampled demonstrated completion of the required training and competency assessments.</p> |
| <p>Subsection 2.4: Health care and support workers</p> <p>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.</p> <p>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.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and</p> | <p>PA Low</p> | <p>Human resources management policies and processes reflect standard employment practices and relevant legislation. All new staff are police checked, and referees are contacted before an offer of employment occurs. A sample of staff records reviewed confirmed the organisation's policies are not being consistently implemented as three-monthly appraisals have not always been completed as scheduled (the service has not yet been open for a year). Each position had a job description. A total of five staff files were reviewed (two HCAs, clinical care manager, RN, and head chef) were</p> |

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| <p>culturally safe, respectful, quality care and services.</p> | | <p>reviewed. Staff files included: reference checks; police checks; appraisals; competencies; individual training plans; professional qualifications; orientation; employment agreement; and position descriptions.</p> <p>Records were kept, confirming all regulated staff and contracted providers had proof of current membership and registration with their regulatory bodies. Each of the sampled personnel records contained evidence of the new staff member having completed an induction to work practices and standards and orientation to the environment, including management of emergencies.</p> <p>The ethnicity of each staff member is documented on their personnel records. A process to evaluate this data is in place and this is reported to the owners/directors at management meetings. Following incidents, the management team is available for any required debrief and discussion.</p> |
| <p>Subsection 2.5: Information</p> <p>The people: Service providers manage my information sensitively and in accordance with my wishes.</p> <p>Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity.</p> <p>As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.</p> | <p>FA</p> | <p>All necessary demographic, personal, clinical, and health information was fully completed in the residents' files sampled for review. The clinical notes were current, integrated, and met current documentation standards. No personal or private resident information was on public display during the audit. Archived records are held securely on site and are clearly labelled for ease of retrieval. Residents' information is held for the required period before being destroyed.</p> <p>The service uses an electronic information management system (Medi-map, interRAI) and a paper-based system. Staff have individual passwords for the medication management system, and interRAI assessment tool. The general practitioner (GP), and allied health providers also document as required in the residents' records. Policies and procedures guide staff in the management of information. An external provider holds back-up database systems.</p> <p>The consent process for data collection is gathered at the time of admission in the resident admission agreement. The records sampled were integrated. The clinical care manager reported that EPOAs can review residents' records in accordance with privacy</p> |

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| | | <p>laws and records can be provided in a format accessible to the resident concerned.</p> <p>The Grange is not responsible for the National Health Index registration of people receiving services.</p> |
| <p>Subsection 3.1: Entry and declining entry</p> <p>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.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p> <p>As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We 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.</p> | <p>FA</p> | <p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs are provided for family/whānau and residents prior to admission or on entry to the service. Five admission agreements reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement.</p> <p>Family/whānau and residents interviewed stated they have received the information pack and sufficient information prior to and on entry to the service. The service has policies and procedures to support the admission or decline entry process. Admission criteria is based on the assessed need of the resident and the contracts under which the service operates. The clinical nurse manager or chief executive are available to answer any questions regarding the admission process and a waiting list is managed as confirmed during interview with the clinical nurse manager and resident and family/whānau.</p> <p>The service openly communicates with potential residents and whānau during the admission process. Declining entry would only be if there were no beds available or the potential resident did not meet the admission criteria. Potential residents are provided with alternative options and links to the community if admission is not possible. The service collects ethnicity information at the time of enquiry and on admission to the service from individual residents, and this is documented on the enquiry form. There is process to combine collection of ethnicity data from all residents. Data is analysed for the purposes of identifying entry and decline rates that is ethnicity focused. The analysis of ethnicity data is verbally communicated between the chief executive and clinical care manager. Formal reporting of this information is included in the chief executive's report to the owners/directors.</p> <p>There are linkages with Māori providers through the chief executive</p> |

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| | | and local providers, who are available to provide support when required. |
| <p>Subsection 3.2: My pathway to wellbeing</p> <p>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.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p> | <p>PA Moderate</p> | <p>Five files were reviewed for this audit (three hospital and two rest home level of care). The clinical care manager and RNs complete assessments and develop care plans. There is evidence of resident and whānau involvement in the interRAI assessments and long-term care plans reviewed and this is documented in the electronic based progress notes. Barriers that prevent whānau of tāngata whaikaha from independently accessing information are identified and strategies to manage these are documented in resident's care plans. The service has no Māori residents; however, the RN's described how the service would support Māori and whānau to identify their own pae ora outcomes in their care or support plan. All shifts begin and end with a karakia.</p> <p>All residents have admission assessment information collected and an interim plan completed at time of admission. All initial assessments and care plans reviewed were signed and dated. A cultural assessment has been implemented for all residents. InterRAI assessments, re-assessments, care plan development and reviews have been completed for residents; however, not all have been completed within the required contractual timeframes or for all residents as required. There were residents who were originally admitted on end-of-life contracts; initial assessments and an initial care plan is on file; however, when the residents transferred to aged residential care contracts, the required interRAI assessments and long-term care plans had not been fully completed.</p> <p>For the resident files reviewed, the outcomes from assessments and risk assessments are not always reflected into care plans. The care plans identify resident focussed goals, recognise Te Whare Tapa Whā and reflects a person-centred model of care. The care plans do not always identify key assessed risks, including medical risks and interventions reflective of interRAI assessments describe in sufficient detail to address assessed needs. Short-term care plans are not used at The Grange, as the care plans are living documents; however, care plan interventions had not always been updated when</p> |

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| | <p>there were changes in health condition and identified needs such as infections, weight loss, and wounds. Challenging behaviour is assessed when this occurs. Routine care plan evaluations had not always been completed as required and did not always document the residents progress towards meeting their goals.</p> <p>Healthcare assistants interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery, this was sighted on the day of audit and found to be comprehensive in nature. Progress notes are written by HCAs and RNs. The RN further adds to the progress notes if there are any incidents, GP visits or changes in health status.</p> <p>All residents had been assessed by the general practitioner (GP); however, not all were assessed within five working days of admission. The GP reviews each resident at least three-monthly. There are GP visits every week and more often when required. After hours support is available twenty-four hours a day, seven days a week. The clinical care manager is available for after-hours calls and advice. When interviewed, the GP expressed positive feedback and stated they were very happy with the standard of care and quality of nursing proficiency. Specialist referrals are initiated as needed. Allied health interventions were documented; however, these were not always integrated into care plans. The service has a contracted physiotherapist who visits four hours per week. A podiatrist visits six-weekly and a dietitian, speech language therapist, occupational health therapist, continence advisor and wound care specialist nurse are available as required. When a resident's condition alters, an RN initiates a review with an GP. Family/whānau were notified of all changes to health including infections, adverse events (accident/incidents), GP visits, medication changes and any changes to health status.</p> <p>Wound assessments, and wound management plans were reviewed. On the day of audit there were eight wounds including skin tears, skin lesions, abrasions, an ulcer and one stage two facility acquired pressure injury. An incident form was completed for the pressure injury. An electronic wound register is maintained. Wound assessments, management plans and evaluations were not always fully completed or completed as scheduled. Registered</p> |
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| | | <p>nurses and HCAs interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources.</p> <p>Care plans did not always reflect the required health monitoring interventions for individual residents. Healthcare assistants and RNs complete monitoring charts including bowel; blood pressure; weight and neurological observations. Neurological observations have been completed for unwitnessed falls and suspected head injuries according to the facility policy. Monitoring charts were not evidenced for food and fluid; pain; behaviour; blood sugar levels; intentional rounding; and or toileting regimes.</p> <p>Residents and family/whānau interviewed reported their needs and expectations were being met.</p> |
| <p>Subsection 3.3: Individualised activities</p> <p>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 are suitable for their age and stage and are satisfying to them.</p> | <p>FA</p> | <p>There is a qualified diversional therapist (activities coordinator) that provides activities Monday to Fridays. They are supported by HCAs and the manager. The activities coordinator has a current first aid certificate. Weekend activities are supported by the HCAs and there are a resources are available to deliver the activities. Volunteers are not currently involved in the service.</p> <p>The programme is planned monthly and includes themed cultural events, St Patricks Day, Easter, Matariki and Christmas. A monthly programme is delivered to each resident which is displayed in the resident's room, as sighted on day of audit.</p> <p>The service facilitates opportunities to participate in te reo Māori through the use of Māori language, Māori language signage during Māori language week, and Matariki. Māori phrases are incorporated into the activities, and culturally focused activities.</p> <p>Activities are delivered to meet the cognitive, physical, intellectual, and emotional needs of the residents. One-on-one time is spent with residents who choose not to or are unable to attend activities.</p> <p>A variety of individual and small group activities were observed occurring at various times throughout the day of audit. Entertainment is scheduled weekly, and outings are scheduled bi- weekly. There</p> |

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| | | <p>are monthly interdenominational services and weekly communion provided by the local catholic church. Tamariki from local playcentres and schools visit to engage with residents, present concerts and share cultural songs.</p> <p>A resident's social and cultural profile is completed within two weeks of admission and include the resident's past hobbies and present interests, likes and dislikes, career, and once a month family connections. A social and cultural plan is developed within 21 days and reviewed three monthly and six-monthly. Residents are encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment, and outings. Activities include morning chats, exercises, bingo, bowls, hand pampering, happy hour, and word games. The service has weekly van drives for outings to local cafes, ice-cream shop, pixie town, local museum, and other sites of interest. The diversional therapist drives the van and has the appropriate competencies and first aid required.</p> <p>Resident meetings have not been held to date (link 2.2.2). There is an opportunity to provide feedback on activities on a one-to-one basis and via family conversations. Residents and family/whānau interviewed stated the activity programme is meaningful.</p> |
| <p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>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.</p> | <p>PA Moderate</p> | <p>Medication management policies are available for safe medicine management that meet legislative requirements. All clinical staff (RNs, and medication competent HCAs) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided.</p> <p>Staff were observed to be safely administering medications. Registered nurses and HCAs interviewed could describe their role regarding medication administration. The service currently uses robotic rolls for regular medication and 'as required' medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>Medications were securely stored in the facility medication room, locked trolley, and locked drawers in the residents rooms. The</p> |

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| | | <p>medication fridge and medication room temperatures are not monitored as per policy. Temperatures in residents locked drawers are not currently monitored. Not all eyedrops and decanted midazolam were dated on opening. All over the counter vitamins, supplements or alternative therapies residents choose to use, are reviewed, and prescribed by the GP. Controlled drugs are stored securely in the medication room; however, weekly checks and six-monthly physical stocktakes were not consistently evidenced.</p> <p>Ten electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three-monthly, and each chart has a photo identification and allergy status identified. There was one rest home resident partially self-medicating (inhalers). The resident has the appropriate assessment and review on file. Medication competent HCAs or RNs sign when the medication has been administered. There are no vaccines kept on site, and no standing orders are in use.</p> <p>Residents and family/whānau are updated around medication changes, including the reason for changing medications and side effects, and this is documented in the progress notes. The RNs described a process to work in partnership with Māori residents and whānau to ensure the appropriate support is in place, advice is timely, easily accessed, and treatment is prioritised to achieve better health outcomes.</p> |
| <p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p> | <p>FA</p> | <p>The meals at The Grange are all prepared and cooked on site. The kitchen is new, well equipped with new stainless-steel equipment and easy clean wall and floor surfaces. The kitchen was observed to be clean, well-organised and well equipped. A current approved food control plan was in evidence, expiring in September 2024. There is a quarterly six-weekly seasonal menu that is developed and was reviewed by a registered dietitian in May 2023. The kitchen manager receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, dairy free, pureed foods) or of any residents with weight loss. The kitchen manager interviewed is aware of resident likes, dislikes, and special dietary</p> |

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| | | <p>requirements. Alternative meals are offered for those residents with dislikes or religious and cultural preferences, including Māori specific options as required. On the day of audit, meals were observed to be presented in a homely manner. Healthcare assistants interviewed understood tikanga guidelines in terms of everyday practice. Tikanga guidelines are available to staff and mirrors the intent of tapu and noa.</p> <p>The kitchen manager completes a daily check which includes fridge and freezer temperature recordings. Food temperatures are checked at different stages of the preparation process by the cook. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen. Cleaning schedules are maintained.</p> <p>Meals are placed in into hot box and delivered to service kitchen for plating. The kitchen manager and chef go and serve directly to residents in the dining room first then deliver plated meals to residents preferring to enjoy meals in their rooms. Staff were observed assisting residents with meals in the dining areas and modified utensils are available for residents to maintain independence with eating. Food services staff have all completed food safety and hygiene courses.</p> <p>The residents and family/whanau interviewed were very complimentary regarding the food service, the variety and choice of meals provided. They can offer feedback on a one-to-one basis with the head chef, with the suggestions form at reception and at the planned resident survey and meetings (link 2.2.2).</p> |
| <p>Subsection 3.6: Transition, transfer, and discharge</p> <p>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.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>As service providers: We ensure the people using our service</p> | <p>FA</p> | <p>Planned discharges or transfers were coordinated in collaboration with residents and family/whānau to ensure continuity of care. Resident change, transfer or termination policy and procedures are documented to ensure discharge or transfer of residents is undertaken in a timely and safe manner.</p> <p>The residents (if appropriate) and family/whānau were involved for all transfers or discharges to and from the service, including being given options to access other health and disability services, social</p> |

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| <p>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.</p> | | <p>support or Kaupapa Māori agencies, where indicated or requested. The RNs explained the transfer between services includes a comprehensive verbal handover and the completion of specific transfer documentation. The service uses the yellow envelope (referral documentation) system.</p> |
| <p>Subsection 4.1: The facility</p> <p>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.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>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.</p> | <p>FA</p> | <p>The facility is purpose-built and is spacious. All building and plant have been built to comply with legislation. The building is across one level.</p> <p>The care centre includes two main wings (one wing is resident rooms) and the other administration and leads to what will be new care suites. The two wings surround an internal landscaped courtyard. There is a secure nurse's office. There is a large, shared lounge which connects to a spacious dining room. All resident rooms have sliding doors that open out onto outside courtyards/patios.</p> <p>The code of compliance expires 1 July 2024. The environment is inclusive of peoples' cultures and supports cultural practices. The chief executive is responsible for small maintenance and there are construction workers on site building the next stages who continue to provide maintenance under warranty. The chief executive oversees maintenance of the site, contractor management and waste management. The owners/directors undertake all ground maintenance.</p> <p>Essential contractors such as plumbers and electricians are available 24 hours as required. Maintenance requests are logged and followed up in a timely manner. There is an annual maintenance plan that includes electrical testing and tagging, resident equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures. Visual checks of all electrical appliances belonging to residents are checked when they are admitted. Annual testing and tagging of resident's electrical equipment was in progress on the days of audit. All equipment was purchased new when the facility opened in July 2023. Checking and calibration of medical equipment, hoists and scales is scheduled for June 2024. Hot water temperatures have been monitored routinely</p> |

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| | | <p>and temperature recordings were within acceptable ranges. There are environmental audits and building compliance audits completed by the chief executive as part of the internal audit schedule. The building has heat pumps in hallways, hot water radiators in rooms and underfloor heating in ensuites. There are individual controls in resident rooms.</p> <p>One of the owners/directors identifies as Māori and has had input into the design of the building.</p> |
| <p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p> | <p>PA Moderate</p> | <p>Emergency management policies, including the pandemic plan, outlines the specific emergency response and evacuation requirements as well as the duties/responsibilities of staff in the event of an emergency. Emergency management procedures guide staff to complete a safe and timely evacuation of the facility in case of an emergency.</p> <p>A fire evacuation plan is in place that has been approved by Fire and Emergency New Zealand. Fire evacuation drills are held six monthly and was last held in March 2024. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Civil defence supplies are stored in an identified cupboard. In the event of a power outage there is back-up power available and gas cooking. The service has access to a generator if required. There are adequate supplies in the event of a civil defence emergency including water stores to provide residents and staff with three litres per day for a minimum of three days. Emergency management is included in staff orientation. It is also ongoing as part of the education plan; however there is not always a minimum of one person trained in first aid available at all times.</p> <p>There are call bells in the residents' rooms and ensuites, communal toilets and lounge/dining room areas. Indicator lights are displayed above resident doors and panels in hallways to alert them of who requires assistance. Residents were observed to have their call bells in close proximity. Residents and family/whānau interviewed confirmed that call bells are answered in a timely manner.</p> <p>The building is secure after hours, staff complete security checks at</p> |

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| | | night. Visitors are instructed not to visit if they are unwell. |
| <p>Subsection 5.1: Governance</p> <p>The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately.</p> <p>Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance.</p> <p>As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.</p> | FA | <p>The infection prevention and control (IP) and antimicrobial stewardship (AMS) policy was developed links to the quality improvement programme; however, the owners/directors have not signed this off as part of the quality plan (link 2.1.11). The clinical care manager is the infection control coordinator, and reported they have full support from the chief executive and directors regarding infection prevention and control matters. This includes time, resources, and training. The staff meetings that have been held included discussions regarding any residents of concern and any infections. Additional support and information are accessed from the infection control team at Health New Zealand - Southern, the community laboratory, and the GP, as required. There have been no infection outbreaks reported since opening. The clinical care manager has a comprehensive knowledge of the outbreak policy and would be able to implement the Ministry of Health guidelines and would report to the chief executive who would report to the owner directors immediately.</p> |
| <p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>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.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p> | PA Low | <p>The clinical care manager coordinates the implementation of the infection control programme. The infection control coordinator's role, responsibilities and reporting requirements are defined in the infection control coordinator's job description; however, the clinical care manager was not able to evidence recent (within the past year) external education on infection prevention and control.</p> <p>The service has a clearly defined and documented infection control programme implemented that was developed with input from external infection control services. The infection control programme as part of the quality plan has not been approved by the owners/directors (link 2.1.11). The annual review for the infection prevention and control programme is reviewed annually, and the review is due in August 2024.</p> <p>The infection control policies were developed by suitably qualified</p> |

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| | <p>personnel and comply with relevant legislation and accepted best practice. The infection prevention and control policies reflect the requirements of the infection prevention and control and control standards and include appropriate referencing. The pandemic and infectious disease outbreak management plan in place will be part of the annual review. Sufficient infection control resources, including personal protective equipment (PPE), were available on the days of the audit. Infection control resources were readily accessible to support the pandemic response plan if required.</p> <p>The infection control coordinator has input into other related clinical policies that impact on health care associated infection (HAI) risk and has access to shared clinical records and diagnostic results of residents. Staff have received education around infection control practices at orientation and through annual online education sessions. Education with residents was on an individual basis as required. This included reminders about handwashing and advice about remaining in their room if they are unwell. This was confirmed in interviews with residents.</p> <p>The infection control coordinator consults with the chief executive on personal protective equipment (PPE) requirements and procurement of the required equipment, devices, and consumables through approved suppliers. The chief executive conformed that the infection control coordinator will be involved in the consultation process for any proposed design of any new building or when significant changes are proposed to the existing facility.</p> <p>Medical reusable devices and shared equipment are appropriately decontaminated or disinfected based on recommendation from the manufacturer and best practice guidelines. Single-use medical devices are not reused. There is a decontamination and disinfection policy to guide staff. An infection control audits has been completed; however, where required, corrective actions were documented; however, there was no evidence of follow-up and sign off (link 2.2.2).</p> <p>Healthcare assistants, and kitchen staff were observed following appropriate infection control practices, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. The kitchen</p> |
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| | | linen is washed separately, and towels used for the perineum are not used for the face. These are examples of the culturally safe infection control practices observed, and thus acknowledge the spirit of Te Tiriti o Waitangi. The Māori health plan ensures staff is practicing in a culturally safe manner. The service has educational resources in te reo Māori. |
| <p>Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation</p> <p>The people: I trust that my service provider is committed to responsible antimicrobial use.</p> <p>Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant.</p> <p>As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.</p> | FA | <p>The antimicrobial stewardship (AMS) programme guides the use of antimicrobials and is appropriate for the size, scope, and complexity of the service. It was developed using evidence-based antimicrobial prescribing guidance and expertise. The AMS programme as part of the infection prevention and control/quality plans has not been approved by the owners/directors (link 2.1.11). The policy in place aims to promote optimal management of antimicrobials to maximise the effectiveness of treatment and minimise potential for harm. Responsible use of antimicrobials is promoted. The GP has overall responsibility for antimicrobial prescribing. Monthly records of infections and prescribed treatment were maintained. The annual infection control and AMS review and the infection control audit (which is planned in August) will include antibiotic usage, monitoring the quantity of antimicrobial prescribed, effectiveness, pathogens isolated, and any occurrence of adverse effects.</p> |
| <p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>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.</p> | FA | <p>The documented infection surveillance programme is appropriate for the size and complexity of the service. Surveillance tools and standardised definitions are available and were available to collect infection data. Infection data is collected manually. Healthcare associated infections being monitored include infections of the urinary tract, skin, eyes, respiratory, and wounds. The infection control coordinator is responsible for collating, and analysing infection data on a monthly basis and reporting the results and corrective actions at the facility meetings (link 2.2.2). Information regarding infections is discussed at handovers and with the RNs as confirmed during interviews.</p> <p>To date one infection prevention and control audit has been</p> |

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| | | <p>completed, including cleaning, laundry and hand hygiene, no corrective actions were required. When interviewed the infection control coordinator and RNs noted there had been very low infections. Residents and family/whānau were advised of any infections identified in a culturally safe manner. This was confirmed in progress notes sampled and verified in interviews with residents and family/whānau.</p> <p>The chief executive included in her reporting to the owners/directors healthcare-associated infections alongside of ethnicity data. There have been no infection outbreaks since opening. Both the chief executive and the clinical care manager were aware of the appropriate notifications required in an outbreak.</p> |
| <p>Subsection 5.5: Environment</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.</p> <p>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible.</p> <p>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.</p> | <p>FA</p> | <p>There are documented processes for the management of waste and hazardous substances. Domestic waste is removed as per local authority requirements. All chemicals were observed to be stored securely and safely. Material data safety sheets were displayed in the laundry. Cleaning products were in labelled bottles.</p> <p>Housekeeping staff ensure that trolleys are safely stored when not in use. A sufficient amount of PPE was available which includes masks, gloves, goggles, and aprons. Staff demonstrated knowledge on donning and doffing of PPE.</p> <p>The housekeepers work seven days a week and are responsible for cleaning and laundry. Cleaning guidelines are provided. Cleaning equipment and supplies were stored safely in locked storerooms. Cleaning schedules are maintained for daily and periodic cleaning. The facility was observed to be clean throughout. The housekeepers have attended training appropriate to their roles. The chief executive has oversight of the facility testing and monitoring programme for the built environment.</p> <p>All resident clothing and linen is laundered on site by the housekeeping staff. There are two laundry areas: one for personals and the other for linen. Both laundry areas have defined dirty and clean areas. Washing temperatures are monitored and maintained to meet safe hygiene requirements. Personal laundry is delivered</p> |

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| | | <p>back to residents in named baskets. Linen is delivered to cupboards in covered bags on trollies. There is enough space for linen storage. The linen cupboards were well stocked with good quality linen.</p> <p>Cleaning and laundry services are monitored through the internal auditing system. The washing machines and dryers are checked and serviced regularly. The infection control coordinator is involved in the implementation of the cleaning, laundry, and audits. At interviews with residents and family/whanau all indicated they were satisfied with the cleaning and laundry processes.</p> |
| <p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p> | <p>PA Moderate</p> | <p>The owners/directors and the facility management is committed to providing services to residents without use of restraint. Restraint minimisation is included as part of the mandatory training plan and orientation programme.</p> <p>The restraint policy confirms that restraint consideration and application would be done in partnership with families/whānau, and the choice of device must be the least restrictive possible. At all times when restraint is considered, The Grange works in partnership with residents to promote and ensure services are mana enhancing.</p> <p>The designated restraint coordinator is the clinical care manager (registered nurse). At the time of the audit, there were three residents using restraint; however, this had not been identified as restraint by the restraint coordinator. The residents using restraint were not documented on the electronic restraint register. The clinical care manager and family/whanau interviewed confirmed the use of bed rails included the resident (where appropriate), EPOA, GP.</p> <p>The use of restraint is reported to owners/directed as zero and does not include the three residents utilising bed rails as restraint. The restraint coordinator interviewed described the focus on minimising restraint wherever possible and maintaining a restraint-free environment.</p> |
| <p>Subsection 6.2: Safe restraint</p> | <p>PA</p> | <p>The restraint policy details the process for assessment. Assessment</p> |

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| <p>The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort.</p> <p>As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.</p> | <p>Moderate</p> | <p>covers the need, alternatives attempted, risk, cultural needs, impact on the family/whānau, any relevant life events, any advance directives, expected outcomes and when the restraint will end. Three files were reviewed of a resident using restraint; however, there was minimal evidence of assessment, monitoring, evaluation, and GP involvement or related care plan documentation.</p> <p>A restraint register is available; however, this has not been implemented. On interview, the restraint coordinator explained restraint is only used to maintain resident safety and only as a last resort. The restraint coordinator on interview stated families/whanau have been involved in the use of the bed rails, this was confirmed at interview). Written consent was not always obtained from each resident and/or their EPOA. No emergency restraints have been required; however, there are policies and procedures documented around emergency restraint.</p> <p>Restraints are required to be monitored in accordance with policy and at least two-hourly or more frequently should the risk assessment indicate this is required. Monitoring forms are available electronically and, in a paper-based format; however, have not been utilised for the three residents currently utilising restraint. Monitoring includes resident's cultural, physical, psychological, and psychosocial needs, and addresses wairuatanga. No accidents or incidents have occurred as a result of restraint use.</p> <p>The use of restraint is a standard agenda item at staff meetings; however, meetings have not always been held according to schedule (link 2.2.2).</p> |
| <p>Subsection 6.3: Quality review of restraint</p> <p>The people: I feel safe to share my experiences of restraint so I can influence least restrictive practice.</p> <p>Te Tiriti: Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions.</p> <p>As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing</p> | <p>FA</p> | <p>The audit schedule was reviewed and included review of restraint use. The content of the internal audit included the effectiveness of restraints, staff compliance, safety, and cultural considerations. The restraint coordinator is responsible for reviewing restraints and the use of restraint would be discussed at the three-monthly GP reviews and approval/review group meetings.</p> <p>Staff are responsible for monitoring restraint related adverse events while restraint is in use (link 6.2.4). There have been no restraint</p> |

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| data and implementing improvement activities. | | related incidents reported for 2023/2024. Any changes to policies, guidelines or education are implemented if required. Interviews with staff (including RN and HCAs) and the GP confirmed that the use of restraint is only used as a last resort. |
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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) |
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| <p>Criterion 1.7.1</p> <p>I shall have the right to make an informed choice and give informed consent.</p> | PA Low | There are policies documenting the informed process. Staff who were interviewed were aware of informed consent processes. Residents and family/whanau understood they had a right to make choices, and confirmed they provide verbal consent where required, however, not all files had consent forms signed by either the resident of the activated enduring power of attorney. | The informed consent forms in five files reviewed had not been signed. | <p>Ensure all residents have a signed consent forms on file as per policy.</p> <p>90 days</p> |
| <p>Criterion 2.1.11</p> <p>There shall be a clinical governance structure in place that is appropriate to the size and complexity of the service</p> | PA Low | The owners/directors are receiving information from the chief executive regarding potential risks, contracts, human resource and staffing, growth and development, maintenance, | <p>i). The clinical governance structure is not yet in place.</p> <p>ii). The quality plan has not been signed off by owners/directors which includes restraint management and</p> | <p>i). Ensure the development of a clinical governance structure appropriate to the size and complexity of The</p> |

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| <p>provision.</p> | | <p>financial performance compliance, ethnicity related to incidents and infections; however, the owners/directors have not signed off the quality plan which includes infection prevention and control and restraint management. A clinical governance structure appropriate to the size and complexity of The Grange is not yet in place.</p> | <p>infection prevention and control.</p> | <p>Grange. ii). Ensure quality plans and information are signed off by the owners/directors. 180 days</p> |
| <p>Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.</p> | <p>PA Low</p> | <p>The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Monthly staff meetings will provide an avenue for discussions in relation to (but not limited to): quality data; health and safety; infection control/pandemic strategies; complaints received; staffing; and education. The Grange's first staff meeting was held in December 2023 and then in March 2024, a further meeting is planned for June 2024. Clinical meetings have been scheduled for one to two monthly. The RNs interviewed confirmed a clinical meeting had been held; however the minutes could not be located. Resident meetings are planned quarterly; however, these have not been evidenced as being held. The clinical care manager has reviewed the data in the months when meetings have been held</p> | <p>i). Meetings are not occurring as planned, two staff meetings have been held, one clinical meeting and no residents/family/whānau meetings. ii). There was no documented evidence of consistent monthly collation, or analysis of quality data. iii). There was no documented evidence of sharing quality data information with staff (other than the meetings held in December and April). iv). Internal audits have not been evidenced as being completed as scheduled since opening in July 2023 – March 2024.</p> | <p>i). Ensure meetings for staff, clinical, resident, family/whānau meetings are held as scheduled. ii). Ensure quality data collation is evidenced as being collated, analysed as per policy. iii). Ensure there is documented evidence of discussions held with staff around quality data collated and corrective actions identified. iv). Ensure the internal audits are completed as scheduled. 90 days</p> |

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| | | <p>(December and April); however, there was no documented evidence of a regular monthly analysis and discussion around trending and corrective actions identified. The quality meeting will be across the two sites and the clinical care manager has started to attend these via zoom.</p> <p>The internal audit schedule commenced in March 2024, and the March and April audits completed.</p> | | |
| <p>Criterion 2.2.5</p> <p>Service providers shall follow the National Adverse Event Reporting Policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learnings.</p> | PA Low | <p>Incident and accident reports are completed on the electronic system. There was evidence that family/whānau are informed of all adverse events; however the electronic forms reviewed did not always evidence timely follow up by a registered nurse and opportunities to minimise future risks were not always evidenced as being identified and implemented.</p> | <p>i). There was no documented evidence of timely RN reviews in the 12 incident and accident forms reviewed.</p> <p>ii). Opportunities to minimise future risks were not documented.</p> | <p>i). & ii). Ensure RN reviews are being evidenced as being conducted in a timely manner and opportunities to minimise risks are evidenced as identified and implemented.</p> <p>90 days</p> |
| <p>Criterion 2.4.5</p> <p>Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.</p> | PA Low | <p>An appraisal policy and schedule is in place. Five files were reviewed, two had completed three monthly and annual appraisals completed. Three staff had been at The Grange long enough to have had a three-monthly appraisal; however these were not evidenced as being completed.</p> | <p>The three-monthly appraisal was not evidenced in the files of the three staff files.</p> | <p>Ensure appraisal schedules are met for all staff.</p> <p>90 days</p> |

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| <p>Criterion 3.2.1</p> <p>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.</p> | <p>PA Moderate</p> | <p>Five files were reviewed. Contractual requirements in relation to timeframes of care plan documentation has not always been met. The clinical nurse manager and RNs are responsible for all residents' assessments, care planning and evaluation of care. The RNs interviewed were new to aged care. There was evidence the resident and family/whānau were involved in the care planning process.</p> | <p>i). Two of five (one rest home and one hospital) resident files did not evidence an initial GP visit within contractual requirements.</p> <p>ii). Five residents (two rest home, three hospital) had not had a long-term care plan documented within 21 days of admission.</p> <p>iii). Two residents (one hospital and one rest home) had no initial interRAI completed within 21 days.</p> <p>iv). One rest home resident was overdue for an interRAI reassessment.</p> | <p>i). Ensure the GP completes an initial visit within five days of admission.</p> <p>ii). - iv). Ensure interRAI assessments, reassessments, and care plans are documented and reviewed within expected timeframes.</p> <p>60 days</p> |
| <p>Criterion 3.2.3</p> <p>Fundamental to the development of a care or support plan shall be that:</p> <p>(a) Informed choice is an underpinning principle;</p> <p>(b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan;</p> <p>(c) Comprehensive assessment includes consideration of people's lived experience;</p> <p>(d) Cultural needs, values, and beliefs are considered;</p> <p>(e) Cultural assessments are completed by culturally competent workers and are</p> | <p>PA Moderate</p> | <p>The service is utilising an electronic resident management system. Assessments and care plans are documented by the clinical care manager and by the RNs in partnership with the resident and family/whanau. The care plans are individualised and reflect resident preferences; however, not all assessments and care plan interventions were documented in sufficient detail to guide the resident needs. Five of five resident care plans reviewed identified insufficient interventions to guide the resident's current care needs. This was identified as a documentation issue only, the RNs and HCAs interviewed could accurately describe the resident needs, likes and</p> | <p>i). One hospital resident did not include sufficient interventions to guide care around restraint, behaviour management, mobility, skin care, continence, end of life cares, pain, seizure management, care of a sub-cutaneous line and nutrition.</p> <p>ii). One hospital resident did not have interventions documented to manage specific mobility requirements, pain, a high falls risk, behaviour management, restraint, and end of life cares.</p> <p>iii). One hospital resident with assessed triggers of mobility, a high falls risk, pressure injury risk and a risk of undernutrition an ongoing pain had insufficient interventions</p> | <p>i). - v). Ensure all care plan interventions are current, individualised and reflect the assessed needs of residents.</p> <p>60 days</p> |

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| <p>accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia;</p> <p>(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;</p> <p>(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;</p> <p>(h) People’s care or support plan identifies wider service integration as required.</p> | | <p>preferences.</p> | <p>documented to guide care.</p> <p>iv). One rest home resident on anticoagulation therapy, a moderate falls risk, a choking risk, pain, and skin protection requirements had insufficient interventions documented to guide care.</p> <p>v). One resident with cognitive decline and triggers of undernutrition and communication had insufficient interventions documented to guide care and contradictory documentation on mobility management.</p> | |
| <p>Criterion 3.2.4</p> <p>In implementing care or support plans, service providers shall demonstrate:</p> <p>(a) Active involvement with the person receiving services and whānau;</p> <p>(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,</p> | <p>PA Moderate</p> | <p>There are comprehensive policies around all aspects of care monitoring and wound management. Post fall management policies include monitoring of neurological observations. Monitoring is scheduled in care plans or on handover sheets for repositioning, and fluid intake, behaviour management and wound management; however, not all monitoring has been completed as scheduled.</p> | <p>i). Monthly monitoring (paper and electronic) of weights were not commenced until March despite residents being admitted seven months previously.</p> <p>ii). There was no documented monitoring of repositioning, restraint monitoring, food and fluid intake, behaviour charts following wandering or verbal and physical aggression for the residents who required this.</p> <p>iii). Six of seven wound charts do not reflect comprehensive assessments, treatment plans or</p> | <p>i)-ii). Ensure monitoring is documented as required.</p> <p>iii). Ensure wound charts reflect comprehensive assessments, treatment plans or monitoring.</p> <p>iv). Ensure wound dressings occur as scheduled.</p> <p>60 days</p> |

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| <p>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.</p> | | | <p>monitoring. iv). Frequency of wound dressings have not occurred as scheduled for five of the seven files reviewed.</p> | |
| <p>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</p> | <p>PA Low</p> | <p>Five resident files were reviewed. Two of these residents had been in the service for more than six months. Routine care plan evaluations for these residents had not always been completed within the six month period, and the care plan evaluation that had been completed did not evidence the residents progression towards meeting their goals. Care plans are designed to be resident centred, holistic and have been developed and reviewed in partnership with the resident and family/whānau.</p> | <p>i). One hospital residents care plan was overdue for the routine six-month evaluation. ii). The care plan evaluation that had been completed did not reflect the residents progression towards meeting their goal.</p> | <p>i). & ii). Ensure the care plan evaluations are completed within expected timeframes and evidence residents progression towards meeting their goals. 90 days</p> |

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| by initiating changes to the care or support plan. | | | | |
| <p>Criterion 3.4.1</p> <p>A medication management system shall be implemented appropriate to the scope of the service.</p> | <p>PA Moderate</p> | <p>Medications are safely stored in locked trolleys, locked drawers in resident rooms and in a locked medication room. Eyedrops, decanted midazolam require dating on opening storage and discarding as per manufacturer's instructions; however, this is not always evidenced. There is a policy in place for the monitoring of the medication room and fridge temperatures; however, temperatures have not been recorded. Resident drawer temperatures where medications are stored including eyedrops are not checked. Controlled drugs are stored securely in the medication room. Legislation requires weekly checks, and six-monthly physical stocktakes; however, this was not consistently evidenced.</p> | <p>i). There is no documented monitoring of medication room or fridge temperatures.</p> <p>ii). Room temperatures in six resident rooms were set at 26 degrees and each residents medication is stored in a locked drawer in the residents' rooms.</p> <p>iii). Three prescription creams in current use with recommended timeframes for use did not evidence opening dates were in use.</p> <p>iv). Two eye drops stored in the residents locked drawer were not dated on opening.</p> <p>v). Three decanted midazolam sprays in current use were not dated on opening.</p> <p>vi). The controlled drug register does not evidence consistent weekly checks.</p> <p>vii). The six monthly physical controlled drug stocktakes have not been documented.</p> | <p>i).& ii). Ensure fridge and room temperatures are consistently monitored as per policy and legislation.</p> <p>iii). - v). Ensure eye drops, creams and midazolam sprays are stored and discarded as per manufacturer's instructions.</p> <p>vi).& vii.). Ensure controlled drug stock checks occurs per legislative requirements</p> <p>60 days</p> |
| <p>Criterion 4.2.4</p> <p>Service providers shall ensure health care and support workers are able to provide a level of first</p> | <p>PA Moderate</p> | <p>Continuing education is planned for orientation, and on an annual basis. Evidence of orientation and planned regular education provided to staff</p> | <p>There is not always a member of staff with a current first aid certificate on duty at all times.</p> | <p>Ensure there is at least one member of staff with a current first aid certificate on duty at all</p> |

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| <p>aid and emergency treatment appropriate for the degree of risk associated with the provision of the service.</p> | | <p>was sighted in attendance records. First aid certificates were held by the clinical care manager and four of the RNs and a number of senior HCAs. Two of the RNs were unable to provide evidence of a first aid certificate. On shifts when the RN did not have a first aid certificate the HCA did not always have a current certificate.</p> | | <p>times. 90 days</p> |
| <p>Criterion 5.2.1 There is an IP role, or IP personnel, as is appropriate for the size and the setting of the service provider, who shall: (a) Be responsible for overseeing and coordinating implementation of the IP programme; (b) Have clearly defined responsibility for IP decision making; (c) Have documented reporting lines to the governance body or senior management; (d) Follow a documented mechanism for accessing appropriate multidisciplinary IP expertise and advice when needed; (e) Receive continuing education in IP and AMS; (f) Have access to shared clinical records and diagnostic results of people.</p> | <p>PA Low</p> | <p>The clinical care manager coordinates the implementation of the infection control programme. The infection control coordinator's role, responsibilities and reporting requirements are defined in the infection control coordinator's job description. The service has a clearly defined and documented infection control programme implemented that was developed with input from external infection control services. Infection prevention and control policies were developed by suitably qualified personnel and comply with relevant legislation and accepted best practice. The infection prevention and control policies reflect the requirements of the infection prevention and control and control standards and include appropriate referencing. The infection control coordinator was not able to locate recent infection control training.</p> | <p>The clinical care manager was not able to evidence recent (within the past year) external education on infection prevention and control.</p> | <p>Ensure the clinical care manager as the infection prevention and control coordinator has completed external education on infection prevention and control. 90 days</p> |

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| <p>Criterion 6.1.4</p> <p>Executive leaders shall report restraint used at defined intervals and aggregated restraint data, including the type and frequency of restraint, to governance bodies. Data analysis shall support the implementation of an agreed strategy to ensure the health and safety of people and health care and support workers.</p> | <p>PA Moderate</p> | <p>Restraint policies confirm restraint use and details of type and frequency will be reported to owners/directors; however, the service has not identified that restraint is in use for three current residents.</p> | <p>i). The service has not reported the use of current restraints at staff meetings, quality reports or owners/director meetings.</p> <p>ii). The service has not analysed current restraint data and reported this to the owners/ directors.</p> | <p>i). & ii). Ensure restraint is reported to governance and data is analysed</p> <p>60 days</p> |
| <p>Criterion 6.1.5</p> <p>Service providers shall implement policies and procedures underpinned by best practice that shall include:</p> <p>(a) The process of holistic assessment of the person's care or support plan. The policy or procedure shall inform the delivery of services to avoid the use of restraint;</p> <p>(b) The process of approval and review of de-escalation methods, the types of restraint used, and the duration of restraint used by the service provider;</p> <p>(c) Restraint elimination and use of alternative interventions shall be incorporated into relevant policies, including those on procurement processes, clinical trials, and use of equipment.</p> | <p>PA Moderate</p> | <p>Restraint policies include an assessment and approval process, a review process, and a focus on restraint elimination; however, the policy had not been implemented as a result of the facilities understanding of restraint.</p> | <p>Restraint policies and procedures around restraint assessments, and approval have not been implemented</p> | <p>Ensure restraint policies and processes are implemented as documented</p> <p>90 days</p> |

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| <p>Criterion 6.2.4</p> <p>Each episode of restraint shall be documented on a restraint register and in people's records in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome of the restraint, and shall include:</p> <p>(a) The type of restraint used;</p> <p>(b) Details of the reasons for initiating the restraint;</p> <p>(c) The decision-making process, including details of de-escalation techniques and alternative interventions that were attempted or considered prior to the use of restraint;</p> <p>(d) If required, details of any advocacy and support offered, provided, or facilitated; NOTE – An advocate may be: whānau, friend, Māori services, Pacific services, interpreter, personal or family advisor, or independent advocate.</p> <p>(e) The outcome of the restraint;</p> <p>(f) Any impact, injury, and trauma on the person as a result of the use of restraint;</p> <p>(g) Observations and monitoring of the person during the restraint;</p> <p>(h) Comments resulting from the evaluation of the restraint;</p> <p>(i) If relevant to the service: a record of the person-centred debrief, including a debrief</p> | <p>PA Moderate</p> | <p>Restraint policies and processes are documented and include assessment including those related to culture, planning and preparation and consideration of an appropriate and safe environment; however, this has not been fully implemented. The restraint register is in place; however has not been maintained.</p> <p>The care plans reviewed of the residents using restraints did not have interventions documented around restraint use, associated risks, monitoring requirements and review.</p> <p>Restraint policies document that the frequency and extent of monitoring of people during restraint shall be determined by a registered health professional and implemented accordingly; however, monitoring charts were not always reflective of restraint use.</p> | <p>i). The service has an electronic restraint register available for use; however, this has not been utilised.</p> <p>ii). Three of three care plans reviewed of residents using restraint did not evidence an implemented process including assessment related to identify potential risks.</p> <p>iii). The use of restraint, and interventions for safe use were not documented in the residents care plan for all three residents utilising bed rails as restraint.</p> <p>iv). Three of three care plans reviewed of residents using restraint did not evidence an implemented process describing the frequency and extent of monitoring related to identified risks.</p> | <p>i). Ensure the electronic restraint register available for use.</p> <p>ii). Ensure assessments are appropriately utilised to identify potential risks.</p> <p>iii). Ensure there are interventions around the use and management of restraints and these are documented in the care plans.</p> <p>iv). Ensure monitoring requirements are clearly documented and implemented.</p> <p>60 days</p> |
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| by someone with lived experience (if appropriate and agreed to by the person). This shall document any support offered after the restraint, particularly where trauma has occurred (for example, psychological or cultural trauma). | | | | |
|---|--|--|--|--|

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

| |
|--------------------|
| No data to display |
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End of the report.