Kiwiannia Care Limited - Kowhai Manor

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

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

The specifics of this audit included:

Legal entity:	Kiwiannia Care Limited
Premises audited:	Kowhai Manor
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 January 2017 End date: 27 January 2017

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: 27

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Kowhai Manor is a facility on the West Coast of the South Island that provides rest home and hospital level care for up to 43 residents. The service is owned by KiwiAnnia Care and managed by a facility manager who works between this and one other facility. A registered nurse has been assisting with the role of clinical manager for approximately a month prior to the audit, as the role has been vacant since November 2016.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, allied health providers and a general practitioner.

This audit has resulted in twenty three corrective actions requiring attention, of which seven are of high risk, twelve moderate and five are low risk. These pertain to complaints management, governance, cover during a temporary absence of the facility manager, all except of the nine aspects of the quality management systems, staff training and staffing levels. Assessment, planning and service delivery processes for residents' care, the activities programme, medicine management, nutrition and food safety, electrical compliance testing and infection surveillance also have areas in which corrective actions have been raised.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Information about the Code and availability of advocacy services is provided in an admission pack. A presentation about the Code has been provided to staff and residents.

Services that respect the choices, personal privacy, independence, individual needs and dignity of residents were being provided. Staff were observed interacting with residents in a respectful manner.

Policy and procedure documents that include information about operating in a manner that honours the Treaty of Waitangi and a flip chart on tikanga were available to guide staff. Relationships have been developed with a local kaumatua who provides support and advice for residents who identify as Maori.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

Positive feedback about the overall level of care and support provided and of recent changes that have been made was provided.

Documentation related to informed consent processes, advance directives and enduring power of attorney meet requirements.

A complaints process is well documented and residents and family members reported that they would speak to the facility manager should the need arise.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

KiwiAnnia Care Ltd is the governing body and is responsible for the service provided at this facility. The governing body has developed various business and strategic plans and documentation which include the scope, direction, goals, values and mission statement of the organisation.

On site, the organisation is managed by a facility manager who took the role in August 2016 following a period with statutory management. There were two months of handover from the previous statutory manager who continues to provide an oversight and monitoring role. Prior to the current facility manager there were three different managers who each introduced different methods and documentation to the management of the facility during the last year.

The owner of KiwiAnnia, who does not live locally, is a registered nurse who provides onsite management from time to time and visits regularly.

A quality and risk management system has recently been purchased and is about to be implemented, this includes re-instigation of the quality and risk management meetings, review and evaluation of reports on quality activities and the reintroduction of an annual calendar of internal audit activity. Systems for reporting and following up on complaints and incidents, health and safety, infection

control, restraint minimisation and resident and family satisfaction have been maintained but not monitored by management to ensure any quality improvements or risk management activities can occur.

The new system includes a suite of policies and procedures that have been introduced in early January 2017.

The human resources management policy guides the system for recruitment and appointment of staff including orientation with all new employees completing the recruitment and orientation process. Staff are encouraged and supported to undertake a range of internal and external training opportunities.

Attracting adequately skilled staff to the area is a challenge for the organisation. Currently staffing levels and skill mix is being managed with rostering and new recruitment strategies. Recent appointment of five new overseas graduates has helped fill some of the vacancies within the roster although there are still obvious 'gaps' many of which are currently being met by casual registered nurses.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in integrated hard copy files. Archived records are retrievable.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The local needs assessment and services co-ordination team is involved in referrals to this facility, however there are not currently any residents being admitted.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by healthcare assistants. Allied health practitioners, such as wound care nurses, palliative care specialists, podiatrists and physiotherapists, are involved as applicable. General practitioners from a nearby medical centre provide advice and undertake medical reviews. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

A wide range of assessment tools are used to guide the development of service delivery plans. Service delivery/care plans are individualised and short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being well informed and that the care provided is of a satisfactory standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

There is a planned activity programme, overseen by a diversional therapist.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses and health care assistants, all of whom have been assessed as competent to do so.

Food is prepared off site and transported up to Kowhai Manor. There were records of the needs and preferences of residents to guide the serving of food. The kitchen area was well organised, clean and meets food safety standards.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Communal areas are maintained at a comfortable temperature. External areas are safe and provide shade and seating.

Waste and hazardous substances are managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Bedrail enablers and lap belt restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews

occurs. Enabler use is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.

Infection control policies and procedures are available to staff to guide the prevention and control of infections. An infection prevention and control programme is documented, an infection control coordinator has been appointed and an infection control committee has been established. There was evidence of access to local district health board and public health expertise for additional advice and support when required.

Staff demonstrated accepted principles and practice around infection control, which are supported with regular education.

Infection control surveillance data is being collected and collated.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	36	0	2	6	6	0
Criteria	0	78	0	5	11	7	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Kowhai Manor has policies and procedures and processes that meet the organisation's obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed. According to reports from staff and residents, an advocate from the local district health board had provided an update on the Code less than one month prior to the audit. These reports were verified in both staff training records and residents' meetings minutes.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Organisational policies and procedures describe expectations around informed consent processes for staff. The facility manager, registered nurse and two care staff interviewed understood the principles and practice of informed consent. All residents' files that were fully reviewed (seven) showed that informed consent has been gained appropriately using the organisation's standard consent form. Among other issues this includes consent for the provision of care, use of photographs, outings, responsibilities around personal possessions and management of their personal information. Separate consent forms are used for vaccinations. Establishing and documenting enduring power of attorney requirements and processes for residents

		unable to consent is defined and documented where relevant in the resident's record. General practitioner involvement is also evident in residents' documentation, as are signed copies of advance directives for applicable residents. Staff were observed to gain verbal consent for day to day care and support processes on an ongoing basis. All but one resident confirmed that they are asked what time they want to do things, and are offered options. Family members spoken with confirmed consent is obtained when they are present and three recalled the written consent document.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with had varying levels of understanding about the advocacy service; however, all knew their right to have a support person and felt there was someone either internal or external to the organisation that they felt comfortable about taking any concerns to. Three staff spoken with were aware of how to access the advocacy service and informed that they had just received training related to consumer advocacy. There were no examples of the advocacy service having been used, or being used, at Kowhai Manor.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The facility has unrestricted visiting hours and encourages visits from residents' family and friends. There was evidence of family and friends coming and going throughout the audit. All family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Community resources are accessed for follow-up by other services such as the district nurses, smoking cessation services and older person's health for example. A visiting hairdresser and podiatrist regularly provide their services on request. Three family members confirmed during interview that staff willingly assist them to take their relative on outings. Residents are provided with assistance from family members, or staff, to access external appointments. There is otherwise limited access to community services, as noted in the corrective action around activities in Standard 1.3.7 due to a lack of resources.
Standard 1.1.13: Complaints Management	PA Moderate	The complaints policy complies with Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available in a number of areas in the facility.

The right of the consumer to make a complaint is understood, respected, and upheld.		The complaints log reviewed showed nine complaints logged since august 2016: two related to residents' spiritual needs not being met, four concerning a resident's care, two concerning staff behaviour and one complaint regarding food. Interview confirmed that the facility manager is responsible for complaints management and follow up. All complaints reviewed showed evidence that each complaint had met the timeframes specified in the Code. Not all complaints verbalised are being documented and managed in the complaints system. All staff interviewed were aware how to assist residents, family and whānau if they wished to make a complaint.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Five of the eight residents and four of the eight relatives interviewed report being made aware of the Code and five residents informed they had received an update about their rights from a 'visitor', who on investigation was a district health board advocate. Because there have not been any recent admissions, staff were reminded of their responsibility to also discuss residents' rights following an admission. Written information about the Code and advocacy services is provided in the admission pack. The Code is displayed near the front entrance together with brochures on the Nationwide Health and Disability Advocacy Service (Advocacy Service), how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	All residents and families who were interviewed confirmed that they are receiving services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Examples included that they are consistently given choices about whether they want to do something, they are not forced to attend activities and that the residents' rooms are private. Staff understood the need to maintain residents' privacy and were observed respecting privacy throughout the audit. For example, staff secured knee rugs that had slipped, talked in lower tones with residents when personal questions were asked, closed doors during personal cares and ensured resident information was held securely and privately by keeping the doors locked. All residents have a room of their own. Residents are encouraged to maintain their independence within the bounds of their abilities. Each resident's plan included documentation related to the person's abilities, and strategies to maximise independence. They included details about how much assistance a person needed to undertake personal tasks such as washing and dressing, eating, mobilising and preparing for bed, for example. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified and documented. Those identified have been incorporated into their individual activities plan alongside the care plans.

		Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. None of the residents and relatives interviewed had seen any incidence of abuse or neglect. A staff report of rough handling by a former colleague could not be substantiated.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Staff and managers reported that the principles of the Treaty of Waitangi (partnership, protection and participation) are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. A policy and procedure on tikanga within the organisational documents, plus a flip chart on display in the nurses' station provide guidance on tikanga best practice. The registered nurse informed that staff in the facility who identify as Māori provide additional support when necessary. Staff support the one resident in the service who identifies as Māori to integrate their cultural values and beliefs at the level they choose. They confirmed satisfaction with their care and appreciate the external input. A kaumatua from the local district health board was interviewed and confirmed she now also provides support and guidance to residents and to staff at Kowhai Manor. There were verbal reports, supported by documented evidence, of an increase in staff cultural awareness for the safety of Maori residents. A recently introduced process for blessing rooms of residents who have passed away was discussed, as was a marae experience that had been organised for staff.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Not all residents interviewed were able to verify that they were consulted on their individual culture, values and beliefs; however, all stated that they do not have any needs related to culture or beliefs, or that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. Examples included family/whanau involvement, priest visits or attendance at religious services, smoking and access to books for reading. A resident satisfaction survey includes evaluation of how well residents' cultural needs are met and this supported that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation. Three residents informed they were not happy in this facility and wanted to be at home, although would not verbalise why. A general practitioner expressed satisfaction with the standard of services provided to residents, although noted examples of when GP decisions had to override the preferred treatment or medicines being advocated by one of the

		registered nurses. The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Staff are guided by policies and procedures, which clearly describe their responsibilities.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	As identified in the corrective actions throughout this report, there are areas where practices need various levels of corrective action. These have been identified in the specific section of the report they relate to. It is noted that residents, family members and staff spoken with unanimously reported that excellent care is being provided and services being provided are of an appropriate standard. The registered nurse informed he maintains his professional development and focuses on aged care. There is now easy access to additional information and support through a quality consultant who is providing guidance on evidence based practices.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	All eight family members stated during interviews that they are kept well informed about any changes to their relative's status, are advised in a timely manner about any incidents or accidents and about outcomes of regular and any urgent medical reviews. This was supported by comments in a family/whanau communication recording sheet in the residents' records reviewed. Residents informed they are told as much as they feel they need to know or want to know with others saying they trust the staff. There was also evidence of resident/family input into the care planning process, although resident input is limited for some because of cognitive decline. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. According to organisational policies and procedures, interpreter services are able to be accessed via the local district health board when required. Contacts for other interpreter services, including internet based, are also included in this documentation. The facility manager who arranges the admissions is aware of a prospective resident's communication needs prior to entry. All current residents were fluent in English and the facility manager informed she has not had the need to access such services for this facility. Hearing aids were in place for three residents interviewed during the audit and two family members reported that they are generally in place when they go to visit and help monitor the status of the batteries.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA High	KiwiAnnia Care Limited is a licensed aged care provider of rest home and hospital care serving the aged population of Greymouth. A board comprising of the owner, who is known as the executive director (ED), an accountant and an HR consultant provide governance to the organisation. The service provider holds a contract under the Aged Related Residential Care Agreement (ARRC) with the District Health Board, which includes the provision of respite care. There is currently an embargo on admissions which has been in place since November 2016. There are currently 27 residents, 16 in the hospital, nine rest home level and two palliative care. The organisation has had a high turnover of managers within the last two years and been under statutory management since mid-2016 until October 2016. A new facility manager was appointed in August 2016. A variety of documentation sighted provided evidence of the direction, objectives and requirements for the organisation, however documentation reviewed was inconsistent or contained different information and lacks clarity. The owner and board have documented organisational performance and this has had some work to align with key performance indicators and the degree of risk identified, however the facility manager reports being unaware of this documentation. The facility manager oversees both facilities owned by KiwiAnnia Care and is expected to provide monthly reporting to the board. The reporting template reviewed shows information to monitor performance and includes financial performance, quality indicators, human resources information, emerging risks and issues. However, as yet, this reporting template has not been completed by the facility manager since her appointment in August 2016. The accountabilities and responsibilities to provide governance and facility management are not clearly defined or understood.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	PA High	A delegated authority policy exists; however, the purpose of the policy is to provide a framework for financial delegated authority only. The clinical manager's role is vacant. An experienced registered nurse has been employed on a temporary contract to assist the facility manager with oversight and support to the registered nurses.

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA High	Minimal documentation was sighted to show evidence of quality and risk activity within Kowhai Manor since July 2016. There have been no quality meetings since July 2016. There was no other evidence provided to show how changes required have undergone any recognised improvement cycle, any outcome monitoring and how changes have been communicated to staff. Organisational management and service delivery related risks have not been identified in a risk register, despite the organisation being in a position of increased risk due to the embargo on beds and the inability to attract and retain senior nursing staff. The facility manager has responsibility for quality management, however has prioritised clinical care needs at the other facility owned by KiwiAnnia care. A new quality and risk management system has been purchased in December 2016 which includes a quality and risk management plan and a suite of policies and procedures, forms and templates. Implementation is yet to commence. The system includes management of incidents and complaints, audit activities, regular patient satisfaction surveys, clinical incidents including infections and restraint minimisation. The new plan utilises the philosophy of lean thinking and uses a 'plan, do, study and act' framework / approach to maintaining continuous quality improvement. A quality strategy and a set of goals and objectives are also documented.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The facility manager described examples of unplanned, adverse or untoward events that would need reporting to different authorities. Such examples included pressure injuries, sudden death of a resident and an infection outbreak. Section 31 is used to report notifiable events to the Ministry of Health (MOH) and District Health Board (DHB). There have been five section 31 notifications in the past year for KiwiAnnia care. Documentation was sighted as evidence that section 31 notifications had been completed. Staff document adverse and near miss events on an accident/ incident forms. A sample of incident forms reviewed show these are fully completed, incidents are investigated, actions developed and actions are followed up in a timely manner. There have been no meetings reviewing these since July 2016, however they are to commence again this month (refer findings in criteria 1.2.3.5 and 1.2.3.6). There is an open disclosure policy for staff to follow and the accident / incident forms sighted all documented that this had occurred and this was verified in the clinical files.
Standard 1.2.7: Human Resource Management	PA Moderate	Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff files reviewed confirmed that the organisation's policies are being implemented and records are systematically maintained. It was evident that this was an area of recent improvement with files recently updated. The administrator performed this function and the files were safely stored in the facility manager's office. Copies of the APCs for those health practitioners who were not employed by the organisation such as the general practitioners (GP's) were also kept on file and were current. All staff had signed contracts. Recent new graduate registered nursing staff employed have all been recruited from overseas. All had evidence of current working visas and New Zealand registration. None have worked previously in New Zealand. An orientation process is available and covers the essential components of the service provided. Four care staff interviewed reported that the orientation prepared them well for their role. Staff files reviewed showed documentation of completed orientation. Sign off of an orientation checklist occurs by the clinical manager/registered nurse. There is a recent process developed and implemented for staff appraisals to be completed three months after commencement of employment and then annually. A register showed appraisals being completed over the last two months. Documentation sighted shows that disciplinary actions, including dismissal, have been taken when service providers have proven unsuitable for their role(s). Staff files and attendance records of in-house training sessions demonstrated that a range of training is being provided, however these records are not always accurate. Documented attendance at core training sessions held since August 2016 was sighted. Sessions held prior to this time were not able to be verified as records were not available. Service providers are encouraged to undertake external education, such as the Aged Care Education (ACE) and Careerforce training. Staff interviewed had never been declined training opportunities. InterRAI training has been attended by registered nurses.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA High	There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery and meet contractual requirements; however, this policy has not been used by the current facility manager. The facility manager states she uses a different method to make staffing decisions. This acuity tool is not documented and was unable to be articulated. The clinical manager role is vacant. Advertising is occurring currently. A roster was reviewed. The roster only shows the current staffing and not what was planned nor captures all of the changes made during the lead up to the rostered shift. The roster does not identify

		senior staff, other than the clinical manager (CM), however on the current roster (sighted), this role is vacant. The registered staff roster shows on the morning shift, one RN with a vacant CM; the afternoon shift shows one RN; and night shift shows one RN across both the hospital and rest home. The minimum number of staff is provided during the night shift and consists of one registered nurse and two health care assistants. Care staff reported that staffing levels vary and that it was hard to replace staff when they are off sick or on leave. Staff reported working over their contracted hours often in a pay period. They reported that the use of casual staff was 'high' and that registered nurse replacement was not easy, as there is no bureau in Greymouth for short notice roster gaps. Casual RNs are rostered in advance onto the roster regularly. The recent employment of overseas new graduates has improved the registered nurse roster, however there are gaps remaining in the roster. Records sighted showed evidence that, of the eight registered nurses listed, two had been employed for longer than one year, three were on a casual contract and three had been employed within the last six months. A staff member with a current first aid certificate is identified on each shift.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Policies and procedures describe requirements around managing residents' information and the managers and staff demonstrated an awareness of the importance of confidentiality of client records. Residents' personal details and information is being entered into the electronic records when a person is admitted. These records were viewed and processes for maintaining this database were described by the administrator. All other residents' records are in a personal hard copy file. Healthcare assistants enter into progress notes under the supervision of registered nurses. This is undertaken once every shift for all residents whether they receive hospital or rest home level care. Medication records are held separately until they are completed and at this point they are archived into the person's file. All residents' records were held securely in a locked cupboard in a room protected by a key pad. Staff were observed to be careful not to leave residents' records open and unattended. Legislative requirements and guidelines around health documentation were being maintained. All records reviewed were legible, integrated and current. Entries were dated and had the signature and designation of the author evident. When ready for archive, residents' records are placed into a file box in a staff only area that enables ongoing success should this be required. When no longer required these are archived according to the year and type of record and stored in a key locked room that was

		checked. As this also serves as a storeroom, the overflow of archive boxes are transferred down to the Granger House site and stored in a room that is locked and where records are retrievable.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Organisational policies and procedures that were presented for review prior to the audit describe the entry processes. As these described processes have only been in place since the end of December 2016 and there is currently an embargo on admissions, it was not possible to assess the level at which the procedures are being adhered to. The facility manager and the registered nurse/clinical nurse manager reported that enquiries or referrals previously came direct to the facility manager and the clinical nurse manager was responsible for undertaking the admission and assessment processes. An admission pack is available and may be provided to people who enquire about services provided, and to new admissions. The pack was sighted and examples of the content included relevant information about the service provider and the services provided, the environment, residents' rights, how to make a complaint and the mission and values of the organisation. Most referrals come via a Needs Assessment and Coordination (NASC) service, which is aware of the entry criteria for Kowhai Manor, however the information is also available on the internet. Assessment processes detail timeframes for various stages of the admission process to be completed. These are consistent with contractual requirements. Residents and family members who were interviewed and who could recall the admission process were satisfied and felt that although it had been a lot to take in all at once, they had had the opportunity to ask questions and some of it made more sense as time went on. A signed and dated admission agreement that meets contractual requirements was in all of the personal files of residents that were reviewed as part of the audit.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	According to organisational policies and procedures, exit, discharge or transfer are to be managed in a planned and co-ordinated manner. An informative transfer form has been developed. Three examples of these having been completed for residents transferring to the local hospital by ambulance were sighted with one person having two on file. There is open communication between the services, the resident and the family. The family/whanau communication record in the files reviewed confirmed contact had been made with next of kin at the time of the transfers. All such transfers were documented in the progress notes. A registered nurse informed that at the time of transition between services, appropriate information, including the completed transfer form, medication records and a copy of the current care plan are provided for the ongoing management of the resident.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	New policies and procedures for medicine management were implemented December 2016. Practices and documentation around medicine management were reviewed as were 11 medicine records of residents at Kowhai Manor. A midday medicine round was observed and correct processes were evident. General practitioners are prescribing and signing for medicines on medicine record sheets. Prescribed medicines in all of the medicine records viewed were signed, pro re nata medicines had their purpose documented and short term medicines had timeframes. Discontinued medicines were all crossed through, signed and dated, reviews were signed and dated within three month timeframes and the allergy status of each person was identified. Two examples of verbal orders had been signed by a GP within 48 hours. Residents' medicines are blister packaged by the local pharmacy that dispenses the medicines for the facility. The medicine trolley was stored securely in a nurses' station when not in use. Prescribed medicines that require additional monitoring were stored correctly, being checked according to legislative requirements and counts of a random sample were correct. Records of the temperature of the medicines fridge demonstrated daily checks are being made and are at a safe level. The pharmacy is responsible for removing any medicines that are no longer required and there was no evidence of excessive supplies of these. Medicine administration records were being signed following administration, except following the administration of topical medicines and this requires corrective action. There are no standing orders used in this facility and the one verbal order found in the sample had been signed by the GP within 48 hours. A medicine reconciliation process for people being admitted to the facility, or returning from the local general hospital was described and a registered nurse informed that recording sheets for these were in place but had been removed. The absence of verification of the reconciliation of medicines needs to be remedied. The registered nurse advised that although there are policies and procedures for the self-administration of medicines, there are no residents who currently self-medicate. A registered nurse described the process around crushing medicines and showed the list of crushable medicines from the pharmacy. There was no evidence of medicines being crushed during the medicine round. Documentation sighted showed that the medicine administration competencies for all staff who administer medicines were up to date. A mix of registered nurses and medicine administration competent health care assistants administer medicines at Kowhai Manor. A list of completed competencies shows that these staff members have current medication competencies. It was noted

		that although staff are commencing syringe driver competencies under the guidance of a registered nurse for palliative care residents, there are no specific competencies for the administration of insulin, as required in the policy documents. This too requires corrective action.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA High	Food is prepared in the kitchens at the sister facility of Granger House. It is transported in a van to Kowhai Manor and transferred into a preheated bain-marie on arrival. Food temperatures are taken and recorded and are sitting within the expected range. However, concerns about low food temperatures were raised in survey responses, residents meeting minutes and verbally during the audit. The reheating of food also has the potential to compromise food safety. This issues needs to be rectified. The service provider is not currently using a menu that has been approved by a dietitian/nutritionist to guide food preparation. The risks associated with this were further exacerbated by the high number of processed foods presented. Without the oversight of a dietitian/nutritionist, it is not possible to ascertain whether residents are receiving adequate nutrition therefore this has been raised for corrective action. Dietary profiles are completed when a person enters the service and copies of this information are provided to the kitchen. Records of food allergies, food dislikes, special diets and the need for modified food, such as moulied or soft food, were on display in the kitchen. Explanations as to how these lists are followed were provided. Due to feedback received of people being hungry because these requirements or preferences have been overlooked, there was limited evidence to demonstrate that these are being upheld when the food is served. This too requires correction. As the kitchen area at Kowhai is primarily used for serving food, there were limited monitoring requirements. Those required, such as the recording of fridge temperatures, the recording of hot proteins temperatures, and the general cleaning schedules are being maintained. Food scraps are placed in a plastic bag that is then disposed of into a general waste skip. There has been a change in kitchen assistants and to date they have not undertaken training in safe food handling.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is currently an embargo on admissions and the facility manager stated that any person enquiring about their services is being informed of this. The owner, the managers and staff interviewed informed that the NASC and the local community of Greymouth and surrounding areas were aware of the current situation and very few enquiries have been received over recent weeks. The facility manager informed that in the past she has made sure she met the prospective client and requested additional information than was available on the referral form prior to accepting them into the service. If it was felt that the person would not fit into the service, or could not be adequately cared for

		then her conversations had been direct with the NASC, rather than the prospective resident and family/whanau. A registered nurse, currently in the role of clinical manager, noted that if the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC would be made. Although examples of internal transfers of people moving from rest home level care to hospital level care were available, no such examples of people moving away unless transferred to the general hospital when unwell were available. Policies and procedures for the organisation outline declining referral/entry to the service.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate	Assessments and interRAI are being completed within the required timeframes following admission and prior to residents' six monthly reviews. Information is documented using validated nursing assessment tools such as a pain scale, falls risk, skin integrity, nutritional screening and behaviour monitoring, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had a range of resident-related information obtained from numerous assessment tools, which were then being used to inform the interRAI. Corrective action is required around the assessment process as interRAI is not being used as the primary assessment tool and because the use of multiple assessment tools, is presenting risk around ensuring accurate information is used for the basis of care planning.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Seven service delivery plans were fully reviewed during the audit of which two were tracers. Four other residents' files were looked at to double check processes such as assessment, reviews, and notes on weights and/or infections, for example. These reflected the support needs of residents plus the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. New care plan formats had been introduced for all but one of the resident's whose files were reviewed, although the old format still provided the required information. Care plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations all being informative and relevant. Different colour pages have been used for different types of services. Updates in the care plans were signed and dated. Changes in care required was documented in progress notes and verbally passed on to relevant staff at handovers at the start of each new shift. Healthcare assistants report that they have verbal input into care planning at times; however, they are not encouraged to read the documentation.

		Residents and families reported that they are not being involved in the development and ongoing evaluation of care plans; although two said they had been informed that a review had occurred and had been told of outcomes. This is an area that requires further improvement.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, such as progress notes and the development of short term care plans, observations, and interviews, verified that the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and that the care provided is overall very good with some marked improvements over time. Care staff informed that although they are not encouraged to read the care plans (refer corrective action in criterion 1.3.5.2) that they receive comprehensive handovers and are confident about speaking with a registered nurse if they are unsure. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. All residents and family members who were interviewed were very positive about the care and support provided.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Moderate	A qualified and experienced diversional therapist oversees the activities programme. During interview, the activities coordinator talked about her role, her focus on one-on-one relationships and described the challenges of implementing the programme. She informed of creative fundraising efforts involving the wider Greymouth community to fund the activities programme as resources were limited. All residents' files that were reviewed had a completed resident profile that had been used to inform a personalised activities plan. Attendance records are kept for the different sessions the person attends. Ongoing evaluation reports have been documented. A monthly activities plan was sighted and copies of three former plans were also provided. The range of activities was limited and there is a greater than expected percentage of activities that do not eventuate. Residents and family members expressed concerns about the value and lack of variety in the activity programme. On the second day of audit, when a more active programme was implemented, there were positive responses to it. A corrective action has been raised to address the quality of the current activity programme for this facility.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive	FA	An effort to transfer all care plans into new formats to ensure consistency with recently introduced policies and procedures had been underway prior to audit. Initially it appeared that the residents had undergone a full review when the new format of care plans was rewritten, however this was not the

and timely manner.		case as noted in the corrective action under 1.3.3.3. Likewise, although six monthly evaluations and reviews have occurred, changes that have occurred for the residents(s) in the interim have not always been captured in the care plan, as was also identified in the corrective action for 1.3.3.3. Regardless of this, the personal files of the tracer and the extended sample, had all be reviewed within the past six months and there was evidence of care plans being changed at these review timeframes. The evaluations were consistent with the goals that were on the care plan and progress notes also demonstrated that reports on specific identified problems and goals are being documented and ongoing reviews are occurring. The electronic database of interRAI assessments suggested that these re-assessments were overdue for the Kowhai Manor residents. An investigation revealed that a final button had not been pushed to trigger the 'completed' signal. External advice was sought and individual records were checked to find that these interRAI have indeed been completed. The problem was being rectified during the audit. On review, all residents whose file was reviewed have had an up to date interRAI assessment within the past six months. As noted in the corrective action for 1.3.4.2 above, assessment tools have been used to contribute towards completion of interRAI data for the evaluations, rather than the other way around. The evaluation and care plan updates reflect the triggers and outcomes identified in interRAI. A nursing diagnosis had retrospectively been added under each goal in all of the care plans that were reviewed. This action was discussed with the registered nurse during the audit. There was no evidence that this had compromised the evaluation of resident's goals, nor their planned interventions. Short term care plans, wound care plans and activities plans were all being evaluated according to documented review dates. A registered nurse undertakes the clinical evaluations and the diversional therapist undertakes the activities evaluations. If a short term problem has become long term, then this has been transferred on to the long term care plan and examples of this having occurred were evident. Such examples included recurrent urinary tract infections for one person, ongoing reviews for a person who has stabilised after an earlier weight loss but remains clinically underweight, and for a third person with congestive heart failure.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or	FA	There was evidence in five resident's files that they had been referred to one or more other health and/or disability service provider for advice or additional support within the past 12 months. Liaison with older person's health and the palliative care team was also evident. The referrals had all been made by the GP. In addition, nurses develop a list for when a podiatrist visits and the podiatry treatment is noted in an allied health recording document in residents' files. Documentation and interviews verified that residents and families were kept informed of the referral process. Any acute/urgent referrals have been attended to immediately, such as residents being sent to accident and emergency in an ambulance

provided to meet consumer choice/needs.		when circumstances have dictated. There are three general practices in the town, all of which have more than one GP. The service provider has one practice that they have closer affiliations with, however the registered nurses informed residents may still choose which GP service they want to use.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	A waste management policy is in place covering disposal of all hazardous substances from the facility. The disposal of waste, hazardous and infectious substances is managed according to requirements and is removed from the premises once a week. Clear documentation around the appropriate bins/ bags to use was evident and actively in use. Staff were able to articulate the processes regarding waste and linen management. The storage area outside is clearly identified and the area was clean and tidy. The chemical storage cupboards were locked and all containers labelled. Appropriate signage is available and displayed as necessary. Material data sheets were available in all service areas and accessible to staff. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. A spill kit was available. Protective clothing is provided for staff and visitors when required. Evidence of protective equipment being used in the utility room was sighted.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate	The building has a current warrant of fitness which is displayed in the main foyer. All associated plant was reviewed and compliant, however currently a sanitiser is requiring replacement and is out of action. A new maintenance person has been employed for the last three weeks and a plan for ongoing maintenance is being compiled. He is an appropriately skilled tradesman and able to manage the facility, however he also understands the need to contact the appropriate tradesman for the work he is unable to undertake. Testing and tagging of electrical equipment is non-compliant in many areas. This was discussed with maintenance person during audit who commenced a list to enable him to remedy this. A maintenance book is kept in the staff room where staff are able to record repairs or faulty equipment that requires attention, such as new light bulbs required, this is signed by the maintenance person once completed. The internal environment minimises risk of harm with ample space to mobilise independently or for wheelchairs to be utilised. There are sufficient toilet and shower areas in both the rest home and hospital wings and these are spacious with clear signage; however, there is an ongoing problem with maintaining water temperatures. Communal dining and lounge areas are spacious with good seating. Externally the areas available are safely maintained and provide seating throughout with a choice of seating under the shade of trees.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible toilet / shower areas located throughout the facility. Toilet doors are easily identifiable with signage and there is a system that indicates if it is in use. The toilet / shower areas were clean and well maintained. Appropriate secured and approved handrails are provided in toilet / shower areas to promote residents' independence where applicable. One room in the hospital wing has an ensuite. Separate facilities are provided for staff and visitors.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided to allow residents and staff to move around within their rooms safely. All bedrooms are single except for one room where a married couple share. Rooms are personalised with furnishings, photos, paintings and other personal items displayed. Mobility aides such as walkers and wheelchairs can be safely manoeuvred in all individual rooms and service areas. Signage is on all personal room doors that enable staff to identify that the resident is currently having personal cares and to not enter the room at this time. These were seen to be used.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are adequate spaces for residents to enjoy activities, dining and relaxing, that are easily accessible by residents. Furniture is appropriate to the setting and arranged in a manner that enables residents to mobilise freely. Residents are able to access areas for privacy.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting	FA	Policies are in place to guide cleaning and laundry services, these include the safe storage of chemicals associated with both areas. Australian and New Zealand codes of practice and laundry standards are also available. Cleaning staff are provided with training to ensure compliance with policy; currently all cleaning staff are undergoing an external training to achieve a cleaning certificate. Water temperatures are monitored closely and recorded, laundry staff are aware of the need to monitor due to the current issue with water temperature, refer 1.4.2.1. Cleaning staff spoken to had a good

in which the service is being provided.		knowledge and understanding of their duties as well as their responsibilities should the facility have an infectious outbreak. An external provider is utilised for “buffing” and carpet cleaning approximately three days a week but can be contacted if required more urgently. A log is maintained of areas requiring extra cleaning. The cleaners’ trollies are stored in a locked area when not in use. Product safety data sheets are available. Facility and personal laundry is undertaken in the facility. The laundry is designed appropriately with clean and dirty flow. There is a lockable cupboard for chemical storage. Regular service calls are made by an external provider and all equipment was compliant with regulations, however electrical testing was not up to date, refer 1.4.2.1. Laundry staff are committed and take pride in the service they provide, complaints regarding the laundering of residents’ personal laundry do not occur.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A disaster and emergency plan is in place and is displayed throughout the facility. The plan was recently implemented, however signed evidence that staff had seen the plan was sighted. The plan covers a full range of natural disasters and also includes man initiated problems such as intrusion and bomb threats. The current fire evacuation plan was approved by the New Zealand Fire Service and a recent training session was held on site. An assigned fire safety officer has had recent training and can describe his responsibilities should a fire occur. Staff interviewed confirmed their awareness of the emergency and fire procedures. The staff orientation programme includes fire training. Adequate supplies in the event of emergency, including food, blankets, batteries, and torches, were sighted and met the requirements for the number of residents. Emergency water supplies were not sufficient at the time of audit; however this was amended prior to the end of the audit. Checks of resources are documented. Emergency power in the form of a generator is available on site. There is a call bell system in place to alert staff, in each bedroom, bathroom and in all service areas. During the audit, call balls were answered in a timely fashion, and there were no complaints logged within the records sighted of complaints related to the answering of call bells. Security policies are in place which encompasses staff safety, car parking and situations that may arise overnight. Staff interviewed felt safe whilst at work.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with	FA	Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All rooms have electric heaters. All residents` rooms and communal areas have opening external windows which provide natural light.

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service provides a managed environment that aims at minimising the risk of infection to residents, staff and visitors through the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, provided as part of the package of documents supplied by a quality consultant. The documents were current as at December 2016. A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. The previous clinical nurse manager/IPC coordinator and a small team had managed infection prevention and control until November 2016. Members of a new infection control committee for 2017, which includes representation from management, health and safety, food services, household management and care and support staff have been delegated, although the operations of the committee have yet to be fully established. The initial meeting was reportedly postponed because of the audit. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities and the IPC coordinator and the facility manager advised that they will send people home if they come to work unwell or have asked staff members to wear a mask when this has been considered appropriate. The facility manager advised that in the event of increased numbers of viral or bacterial infections in the local community, signage would be placed at the main entrance to the facility requesting anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Signage is also available for use in the event of an internal infectious disease outbreak, such as norovirus.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has yet to undertake training specific to the role. Meantime, the organisation is reliant on access to other organisations and specialists with expert knowledge in infection prevention and control. There are established links with the local district health board infection control team, the local public health unit and the GP practice they primarily liaise with. These links are noted in the infection control manual. Discussions about how and who to access were undertaken and at the same time the facility manager described well-established links to broader regional infection control networks. The IPC coordinator and other registered nurses have access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator and the facility manager confirmed the availability of resources to support the

		programme and any outbreak of an infection.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were dated December 2016 and include appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers and use of disposable aprons and gloves. Hand washing facilities and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. During the audit a staff person breaching good infection prevention and control practice was corrected by the facility manager and reminded of correct practice.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. The latest infection control education was provided in September 2016 by the infection prevention and control nurse from the local district health board. Content of the training was documented and an evaluation to ensure its relevance and understanding was reported to have been made. Evidence of this was not sighted. A record of attendance at education is maintained and was sighted. The IPC coordinator informed that when there was a suspected outbreak of norovirus at the sister organisation of Granger House, staff were reminded of their responsibilities around infection prevention and control techniques. The IPC/registered nurse informed that education with residents is generally on a one-to-one basis and has included reminders about the importance of drinking fluids, especially in warmer weather, and of handwashing. It was noted when looking at residents' meeting minutes that residents had been reminded of the reasons why maintaining personal hygiene, especially handwashing, was important to prevent them from becoming unwell.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed	PA Low	The new infection prevention and control surveillance programme that goes with the newly released organisational documents has yet to be fully implemented. The planned infection surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a

objectives, priorities, and methods that have been specified in the infection control programme.		focus on symptoms rather than laboratory results. Once fully implemented the organisation will have access to nationwide benchmarking with other aged care facilities. Meantime, when an infection is identified, a record of this is being documented on an infection incident form and in the resident's personal file. Until November 2016, the previous clinical nurse manager for Kowhai Manor was the IPC coordinator. A senior registered nurse has been in the IPC coordinator role for one month and is familiar with the collection of data around the incidence of infections and was able to produce data and graphs. There was no evidence of an analysis of the data, especially in relation to a spike in urinary tract infection. The need for surveillance for infections to be undertaken according to the objectives and methods described in the infection control programme requires improvement. As identified in the corrective actions in section 1.2.3, the reporting of infection control data into the quality management system is not occurring because of the breakdown of both the review of quality improvement data and the functioning of quality and risk management systems.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures for restraint minimisation and safe practice are in place. There are clear definitions of a restraint and an enabler. Staff interviewed were able to articulate these. There are appropriate policies and procedures to guide staff actions related to restraint and enabler use. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated sound knowledge and understanding of the organisation's policies, procedures and practice and the responsibilities of this role. On the day of audit, three residents were using enablers, which were the least restrictive and used voluntarily at the request of the resident. There were no residents using restraints. The organisation has a robust process which ensures the on-going safety and wellbeing of the residents. A resident's file sighted showed evidence of the use of an enabler for safety purposes. This process was documented clearly. Restraint is used as a last resort when all alternatives have been explored. The approval, reviews and monitoring systems were evidenced in the residents' files reviewed. Approval meetings are held. Regular discussion occurs for all residents who have approved restraints.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint	FA	The restraint review committee are responsible for the approval of the use of restraints and the restraint process, as defined in policy. Residents' general practitioners are also included in the decision making and have a key responsibility in the process. It was evident from review of the restraint register, approval group meeting minutes, and review of residents' files that there are clear lines of accountability, that all restraints are approved, and the overall use of restraints is being

processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		monitored and analysed. There is evidence of family / whanau involvement in the decision-making process, as is determined by policy. The use of a restraint and/or an enabler is included in the care planning process and is part of evaluation.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator`s input as required. The restraint coordinator interviewed described in full the assessment process. The documentation reviewed demonstrated that the family/whānau and general practitioner was involved in the final decision on the safety and use of restraint. All aspects in the review/evaluation process are considered, for example, the identified underlying aetiology, history of restraint use, cultural requirements, alternative de-escalation strategies and any identified risks. The long-term care plans were updated and the desired outcome to ensure resident`s safety and wellbeing was documented. Completed assessments were sighted.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	All approved restraint is only used as a last resort for safety reasons. The use of restraint is clearly minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members before use of a restraint is implemented. When a restraint is in use, monitoring occurs at the designated timeframes to ensure the resident is safe and that dignity and privacy is maintained and respected. A restraint and enabler register is maintained and updated monthly and reviewed at each restraint approval group meeting. Sufficient information is documented to provide an auditable record. Registers prior to mid-2016 were not sighted. Staff receive training at orientation and this is an on-going annual requirement. Training on the policies and procedures and related topics, such as challenging behaviour management and de-escalation techniques, occurs. Staff interviewed understood that the use of restraints is to be minimised and safety was paramount.
Standard 2.2.4: Evaluation Services evaluate all episodes of	FA	Review of residents' files evidenced the individual use of restraints/enablers was reviewed and evaluated during the care plan and interRAI reviews. All reviews are discussed at the restraint group meetings. The evaluation includes all requirements of the standard, including future options to

restraint.		eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation was completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint committee meet and review all episodes of restraint/enabler use. This is documented in the meeting minutes. At the individual resident level, it was evident that review and evaluation occurs. The restraint register demonstrates a downward trend in the use of restraints. Evidence of discussion with mental health specialist regarding alternative methods of managing residents' behaviour was sighted. No evidence demonstrated that reviews direct staff education and ongoing training needs. Refer to findings/comments in criteria 1.2.3.6 The internal audit process includes restraint minimisation and safe practice. The new document system recently implemented at Kowhai Manor does provide the mechanisms to feed into the quality management system.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Moderate	A complaints log is in place, complaints (nine) have only been documented on this log since August 2016. No previous complaints log could be located when requested. The log is reviewed and includes date received, when acknowledged, follow up letter date and if a meeting held with complainant and the date resolved. All nine complaints reviewed demonstrate timeframes are met and actions were taken to address the complaint. Discussion with staff and family members indicated that there are more complaints received than documented on the register. Resident meeting minutes note residents’ dissatisfaction with the food on numerous occasions, however there is only one complaint logged on the complaints log regarding food. Whilst on site food complaints were constantly made to the auditors, residents and family members approached the auditors whilst on site to complain about the food. Complaints regarding quality of food were also sighted in residents’ meeting minutes, however were not in the complaints log.	The complaints register is not maintained and does not include all complaints received.	An up to date complaints register is maintained. 90 days

Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA High	A range of documentation was reviewed. Documentation lacks consistency and clarity to provide guidance for governance and management of the facility. The strategic and business plans have been developed by the board. Two different business plans were sighted for the organisation, one given as a separate document and the other one provided with the new documentation currently being implemented. There is variance between the two plans. One has six objectives and the other nine objectives; however, they are not the same. An e-mail confirmed that one version of the business plan has been provided to the facility manager at the same time as a reporting template. The reporting template has not been used by the facility manager since her August appointment. The facility manager had not seen the strategic plan at the time of audit. Refer findings under this standard in criteria 1.2.1.3	Strategic and business planning, including goals and objectives for the organisation, are not clearly identified.	Ensure one current, up to date version of the strategic and business plan is available and understood by management and staff. 30 days
Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.	PA High	There was no document sighted to provide information regarding devolving clinical responsibilities of the organisation. The ED backs up the facility manager in any absence, although this is not documented in any delegated responsibility policy. A delegated authority policy (January 2015) was sighted for financial authority. A vacancy for the clinical manager role is currently being advertised. The role has been vacant since November 2016. During the audit an experienced registered nurse (RN) was made available to assist the audit team; however, the RN is normally on rostered shifts.	The facility manager does not have a formal process available for back up, although understands that the owner would fulfil this role. There is no delegated responsibility documentation. There is a current vacancy for the clinical manager's role.	A suitably qualified and /or experienced person be appointed to the role of clinical manager. A delegated authority policy defining responsibilities around cover of any temporary absence of the facility manager and clinical manager roles is documented and

				implemented. 30 days
Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.	PA High	The quality meeting structure was in place until July 2016, with two different formats driven by two different managers. Minutes of meetings on quality and risk were not sighted since July 2016 and staff interviewed confirmed that they had not attended any meetings since this time. The ability to review previous documentation related to any quality activity was either onerous or not available. There is a plan to reinstate monthly meetings, commencing this month, using a new framework provided by the external quality advisor. This framework will meet all the quality reporting needs of a quality and risk management system. Information such as training records were obtained from the financial administration clerk and the manager, some records were on the training register and others in a separate file elsewhere. The facility manager on interview was not aware of an organisational risk register. Documentation was sighted after the audit, labelled 'Risk analysis for KiwiAnnia', however it was unclear where this originated from as it was not document controlled or signed.	The quality and risk management system has not been implemented since July 2016. Risks are not adequately identified, reviewed, monitored and reported on. Refer all findings under this standard in criteria 1.2.3.3, 3.4, 3.5, 3.6, 3.7, 3.8, and 3.9.	Implement and maintain the quality and risk management system 30 days
Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by	PA Low	New policies and procedures were in circulation and had been sighted and read by a number of staff, as evidenced by the signing sheet at the front of the manual. It was evident by the date that this manual had been provided to the staff the day prior to this audit. Not all staff had completed reading the manual. Staff interviewed were aware that it had been circulated but due to lack of time in their day had not looked at it to date. There was no date evident by which this manual was to become 'live' although previous policies and procedures were not sighted in the clinical areas. There was no evidence in the facility of written documentation to advise staff of the change to the policy and procedure manuals. The new policy and procedure manual has been provided by an	A new system including policies, procedures and form templates has been purchased and is now in the process of being implemented. There is no implementation plan documented,	Formulate a plan to implement the introduction of new policies and procedures. 180 days

policy.		external provider and is aligned with current good practice and meets legislative requirements. The ED during interview provided policies on delegated authority and staff rationale policy both of which were in various formats and not aligned to the new system.	however evidence seen on site shows some of the documents in use and the folders with policies and procedures at work stations for staff reference.	
Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Low	On reviewing documentation within the facility, it was evident that despite a good attempt at removing all previous documentation, a number of 'old' documents remained in circulation. Document control is controlled by the external provider and a section in the recently provided package of quality management documents the 'quality assurance and risk management plan' details how ongoing suitability and management of documents will occur. The facility manager interviewed did not yet understand the process. There are new folders in ward areas that contain policies and procedures. These were introduced in early January, however staff report they have not had related training to date. There are copies of policies, procedures and forms that have been used prior to the introduction of the new system still available and in use. Documents in use are currently a mix of old and new. This includes policy from the Board having no evidence of document control. The manager reports that as new documents replace the old, the old are being archived. New fire / evacuation plans sighted had been distributed to all areas, but key information had not been altered on the documents to ensure they were site specific, for example the telephone number and address on the sheet of instructions of 'what to do' was incorrect.	The document control system is not implemented for all documentation and there is no plan to do so. Obsolete documents have not been removed from circulation with a mix of old and new documents available for use. Not all documents have the necessary document control details. Site specific details are incorrect on the fire/evacuation plan distributed.	Document and implement a process to introduce new documentation into the organisation and maintain document control. 180 days

Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Moderate	There have been no quality and risk meetings since July 2016. Data from incidents and infection rates was sighted and is collated and graphed, however is not being reviewed or evaluated. It currently stays with the administrator who enters the data. Complaints data is not collated or reviewed. Complaints are entered into a log and this tracks that each complaint is progressed, but not any trends. On interview, the facility manager is aware of this gap. A template for reporting has been provided by the external consultant that includes reporting on all relevant data from key components of service delivery. This is not yet implemented. A calendar schedule for reinstating the quality meetings has been developed.	No evidence was seen of quality data linking into the quality management system.	Reinstate the monthly quality meetings as per the plan, ensuring these include review of all quality and risk components. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Data has been collected, principally in the areas of incidents, infection control and restraint management, and has been collated by the administrator. There was no evidence sighted of analysis of this data. Nor any evidence that analysis leads to documenting a plan for service improvements and staff training/education. No benchmarking with other KiwiAnnia care facility or external organisations was evident. There was no evidence of data being collected relating to health and safety or complaint. There was little data available prior to August 2016, and thus any trend in data was difficult to detect. Staff interviewed were not aware of any process related to information being gathered, such as incident reports and how this fed into the quality and risk management plan. There was no evidence sighted of outcomes of incidents being fed back to staff.	Insufficient data is being gathered, analysed, evaluated and communicated to staff, in all areas that would normally be expected in relation to quality and risk.	Quality improvement data is gathered, analysed to identify trends and evaluated, and this information is reported to staff, and where appropriate residents/families. 90 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is	PA Moderate	There have been no quality meetings since July 2016. The framework for quality and risk planning has only been provided in December 2016 and is now in the process of implementation. Refer also to criterion1.2.3.1	There is no implemented quality and risk management plan.	Implement and monitor achievement against the quality and risk management

implemented.				plan. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	Corrective action plans sighted were hand written in varying formats and were all in response to corrective actions raised by previous audits and due to the need to report these back to the Canterbury District Health Board, SIAPO and HealthCert. Corrective actions plans were sighted in two places in slightly different formats. Staff document adverse and near miss events on an accident/incident forms. A sample of incident forms reviewed show these are fully completed, incidents are investigated, actions developed and actions are followed up in a timely manner. Corrective action plans were not completed for complaints and there was no evidence sighted of other plans being developed from internal audit activity, such as infection control.	The corrective action planning process and quality improvement system is not yet capturing all areas where formal corrective action should occur.	Implement the corrective action process as defined in the new quality system. 90 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the	PA High	The risk management system has been documented and provided by the external quality contractor in December 2016. The facility manager has not yet had time to review this system. The new risk register (included in the templates provided in the purchased programme for quality and risk management) includes plans for standard rest home, hospital operations including environment, resident safety, adverse events, financial and staffing; however, there are no risk management plans documented related to the last few months' regular management changes or management and governance level risks. The facility manager is unaware of all risks needing to be reported to the board. As with complaints, risks are often dealt with 'in action' and not documented. There was no evidence sighted of a risk assessment tool to aid analysis and rating of risks. A risk analysis for KiwiAnnia document was provided to the auditor the day prior to audit. This document was incomplete, not dated, nor on	There is no implemented risk management system. Risks are not reported formally nor reviewed by managers or directors.	Implement and ensure reporting, regular review and monitor of the risk management system as required for each management level in the organisation. 30 days

severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.		formal letterhead and there was no identification from where / who it originated. The owner/ directors have set up a reporting template that does not include risk. This has not yet been implemented as a regular reporting framework. There is no requirement for risk reporting from the manager in the current manager's key performance indicators.		
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	A lack of training records was described by the facility manager prior to August 2016; however, it was difficult to ascertain the validity of this due to training records being stored in various areas. Throughout the duration of the on-site audit further records previously declared as not available become evident. Training records sighted were not always recorded accurately, for example, training offered on the 6 July 2016 was signed by five staff members as attending, but this education session was not held due to the presenter not arriving. This training was to be repeated one month later when seven staff attended according to the attendance sheet, however, once again, the presenter did not arrive. Core training recorded in staff files could not always be validated by training sheets. Staff interviewed stated that mandatory training did not always occur in the past and that a follow up for non-attendance was not pursued. The facility manager was currently implementing an annual training plan	Evidence of staff having attended core training has not been able to be located for 2016 to validate that all staff have attended core training as required.	Provide evidence that all staff have received the necessary core training. 90 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA High	There is a KiwiAnnia Care rationale for staff levels and skill mixes, however the facility manager stated this was not provided to her until the audit, and she has been using a different rostering system. The staff roster does not identify skill level or seniority of registered nurses. Staff lists were reviewed - KiwiAnnia registered nurses, KiwiAnnia healthcare assistants and full KiwiAnnia care staff lists, all dated the 24 January 2017. There were variances identified between the lists and further variances when the roster was sighted, thus making clarification of staff rosters difficult to validate. Names appeared on	The staffing rationale policy is not being implemented and the rostered hours do not meet the staff level cover required.	There is adequate staff cover over all shifts, including registered nurses, that meet the KiwiAnnia staffing rationale requirements and

		rosters that were not on staff lists and names on staff lists were not evident on the rosters. Policy states that the on call registered nurse will be identifiable on the roster, this was not evident. On discussion, the facility manager is filling the need for an on-call person seven days a week. The guideline for staffing states eight hours per resident per week for hospital level patients and two hours per resident per week for rest home level patients. Registered nurse hours did not meet this guideline. On review of the next week's roster, 21 registered nurse shifts are required, 18 were currently filled at the time of audit, four of these shifts were with a RN on a casual contract, five shifts were covered by a new graduate employed since December 2016, and four shifts were covered by RNs who have been employed for the last four and six months respectively, with the remaining five shifts covered with an experienced RN who has been employed for three years. Evidence of previous rosters and time sheets were sighted. A registered nurse had worked 100 hours in previous pay period, contracted hours were 64 hours. Care staff also reported working more hours than contracted hours. Evidence was seen of one staff member working nine days in a row including split shifts that totalled 12 hours in a day and was over their contracted hours. Another example was sighted where they had worked eight days in a row of eight hour shifts and in the first seven days had been 11 hours over their contracted hours. On interview staff expressed concern regarding staffing levels, in particular at the weekends. When staff phone in sick, the facility manager is not always informed. The facility manager states that the administration staff can make the decision to replace or not. There are five new graduates recently appointed with three having started. It is not clear how the senior staff will support new graduates with the current staffing rationale documentation. On review of the next month's roster, it was evident that new graduates are rostered on shifts without support from another registered nurse on duty, however the facility manager states she is available at all times.	Documented human resources records do not match the rostered names. There are new graduate positions with limited evidence of oversight to ensure competency. The rostering does not account for skill mix.	needs of residents. The skill mix and competency of staff ensures safe staffing. 30 days

		E-mail communication does demonstrate active planning to fill some roster gaps including the facility manager filling short shifts. All registered staff have a current first aid certificate, other than new RNs recently appointed. There is a clinical manager role being advertised. The role is not currently filled; however one RN was made available during the audit to assist the auditors.		
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	A range of topical medicines/dermatological preparations are being prescribed. The service provider only requires two preparation that have steroids in them to be signed for and examples of signing sheets for these were sighted. Two examples of the administration of such creams having been given were sighted in progress records; however, these were not consistent with the prescription records. There were no other signing record sheets for the administration of topical applications. Competency assessments have been completed and are current for all staff who administer medicines. Registered nurses are being coached with support from a district nurse to develop their competency in the use of syringe drivers for residents who require palliative care. There are reportedly two people who require insulin administration; however, there is not currently any staff competency assessment undertaken for the management of residents with diabetes who require insulin. The registered nurse described previously implemented reconciliation processes that included signing off that they had been undertaken. The form associated with this process had been removed and although checks are reportedly being done, there is no evidence, except for a signature on blister packs of the wider range of medicines being checked.	The safe administration of medicines is compromised as there are not currently administration records of prescribed topical applications that contain active pharmaceutical ingredients and staff are not completing competencies for insulin administration. Staff reported that the medicine reconciliation processes that were in place have ceased, therefore there was no documentation	Records of administration for all medicines are kept, including for topical applications. Staff responsible for managing residents with diabetes demonstrate competency in the administration of insulin. Medicine reconciliation processes are signed as they are completed. 60 days

			available to demonstrate checks are made.	
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Moderate	A menu for this facility was reviewed two years ago by a registered dietitian and a copy of this was sighted. Food service staff informed that the items on that menu were not liked by residents and options for a new menu are now being explored. This comment was validated by the facility manager. As there is not currently any menu being followed, it could not be confirmed that the nutritional needs of residents are being provided in line with nutritional guidelines. There was also evidence of a high use of processed items with corned beef, saveloys and crumbed fried fish bites all within 24 hours.	Meals are not currently being provided according to a menu that has been reviewed by a dietitian, therefore there is no certainty that meals are in line with recognised nutritional guidelines.	Food, fluid and nutritional needs of the residents are provided according to input from a dietitian to ensure it they are in line with recognised nutritional guidelines. 30 days
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA High	The standard requires that residents who have additional or modified nutritional requirements or special diets have these needs met. Clause D15.2 b of the ARRC agreement states that the food service will also take into account the personal likes/dislikes of the residents. Dietary profiles are provided to the cook and to the kitchen staff to ensure they are aware of needs and personal preferences of residents. A quality of life questionnaire undertaken with residents in November 2016 identified concerns around food that were further validated by residents, family members and staff. The minutes of one to two monthly residents' meetings repeatedly report concerns about cold food, insufficient food, no choices, residents going hungry and unsuitable food options. During the audit, there was evidence of there not being an option for people who did not like the main meal item and one person informed us she was going to bed hungry as there was no option. A person with multiple food allergies (who despite currently having stable weight is also clinically diagnosed as underweight) does not always get suitable food, snacks were not made available when	Residents who have additional or modified nutritional requirements or special diets are not always having these needs met as required in this criterion of the standard. The foods provided are not currently taking most residents' likes and dislikes into account as	Dietary profiles provided to the kitchen staff are accurate and the information contained in them is upheld to ensure residents who have additional or modified nutritional requirements, special diets or specific food likes and dislikes, have these needs met.

		people are hungry and there were reports of insufficient or poor quality meals from all but three of the sixteen residents and relatives interviewed. In all but two cases, the request for information about food had not been asked before it was provided. One of six dietary profiles checked with residents was inaccurate with a food sensitivity recorded as a food dislike. Family members confirmed residents' reports that they are bringing in packets of biscuits and supplementary meals to counter reported lack of food, which on investigation appeared to be due to dislikes and intolerances/allergies being disregarded.	required Clause D15.2 b of the ARRC agreement.	30 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	Food is prepared in the kitchens at the sister facility of Granger House. It is transported in a van after being heated to high temperatures, transferred into pre-heated containers, then into a van for transport up to Kowhai Manor and finally into a preheated bain-marie on arrival before it is served. Despite food temperature recordings indicating they are within the expected range, complaints from residents and from relatives on their behalf, about the low temperature of the food were ongoing during the two days of audit. Staff, residents and family members also reported that there are frequent delays in the food arriving at Kowhai Manor and this was evident on one of the days of audit. The kitchen assistants at Kowhai Manor have not yet attended training in safe food handling practices.	The kitchen assistants have not undertaken training in safe food handling practices. The food is being transported from the kitchen at Granger House up to Kowhai Manor in a van. This is compromising the temperature of the food, especially as there are frequent delays in the food reaching Kowhai Manor.	Kitchen hands undertake safe food handling training to ensure safe food handling practices are maintained. The system for transporting food between Granger House and Kowhai Manor ensures food is kept at the correct temperature and it is hot enough for residents to enjoy, to maintain food quality and to maintain food safety. 30 days

Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.	PA High	In an effort to bring all service delivery/care plans in line with new documentation formats released to the organisation at the end of December 2016 before the audit, a registered nurse has worked excessive hours and an external person was brought in to provide assistance. The external person is well qualified but is not familiar with the residents. The new forms were being dated and the information in the old version care plans was being transferred across without full reviews occurring. It is unclear if the direct transfer of information was the cause in all cases, but during review of residents' files, discrepancies were found in the information in different sections of files. This included discrepancies between what residents, family members and staff were saying and what the care plan stated. The most extreme example was a care plan that was randomly selected to check reasons for the weight record. The care plan described the resident as able to make her own decisions, what she eats and how she is transferred, for example; however, the resident was in fact receiving end-of-life cares, which is well documented in progress notes. The care plan had been updated late December 2016, however ongoing deterioration meant these details were no longer relevant. A further update was undertaken by the registered nurse when the issue was raised during audit. Examples of other discrepancies involved differences between a doctor's report and the nursing care plan around a resident's weight. One part of a care plan said a person had a catheter and another said pads were in use and did not say why and nor were catheter cares referred to in the assessment. One plan noted a food sensitivity as a dislike; two did not have a resident profile, however there were evaluation and progress notes against absent activity goals. It was unclear how often a person diagnosed with congestive heart disease was meant to be weighed. The frequency of monitoring of the blood sugar levels was unclear for a person with diabetes, as although it said annual checks by the GP, there were recording of levels in progress notes. Details in the care plan of one person were inconsistent with the reported needs and goals as described by the resident and his family members.	Despite service delivery plans being comprehensive and their reviews documented as being up to date, there was evidence of multiple discrepancies in information in different sections of residents' files, which had the potential to compromise the level of care and support provided.	The date of rewritten service delivery plans accurately reflects the needs of the resident(s) at that point in time. The content of the service delivery plans accurately reflect the needs of the resident and each stage of service provision is undertaken by staff who are fully conversant with the needs of the resident(s). 30 days

Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	The review of residents' files showed that multiple assessment tools are being used for the same issues over a range of potential problems for all residents. For example, three, four and five different nutritional assessments were on file; and/or three, four or five different assessment tools for mobility or falls risks; and/or two types of pain assessments; and/or two or three tools for skin integrity. Not only were these being used to inform interRAI, rather than using interRAI as the primary assessment tool, but the use of so many has the potential to confuse the real issues required for care planning and service delivery interventions.	InterRAI is not being used as the primary assessment tool, as required in D15A of the ARRC agreement. A variety of assessment forms for the same potential problem are being used when a resident is admitted, or a care plan is reviewed and the information is being used to inform interRAI. The use of numerous assessment tools has the potential to compromise the integrity of the care plan.	A co-ordinated process is required around the use of interRAI and associated assessments to ensure the needs, outcomes and/or goals of the residents are accurately identified and form the basis for service delivery planning. 180 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve	PA Low	According to the ARRC agreement, each resident and his/her family/whanau will have the opportunity to have input into the resident's care planning process. Also, care plans are required to be available to all care staff to guide the care delivery provided according to the relevant staff member's level of responsibility.	Residents and family members are not having the opportunity to have input into the resident's	Each resident and his/her family/whanau will have the opportunity to have input into

the desired outcomes identified by the ongoing assessment process.		Residents, and family members who were asked, had not been invited to have input into the care planning review processes, although two said they were told of outcomes. Registered nurses informed they do not have time to formally consult with family members, but use information from ongoing informal discussions during their visits to assist them with planning and reviews. Health care assistants informed that although they have physical access to residents' records, they are not encouraged to access them, do not have time to read them, and it is not the usual process for finding out how to care for the residents. It was reported that the registered nurses will ask healthcare assistants for feedback about residents, but they are unaware of what happens to the information they provide.	care planning process and nor are healthcare assistants supported to use documented care plans to guide care delivery, as required in Clause D16.3 (f) of the ARRC agreement and Clause D16.3 (l) of the ARRC agreement respectively.	the resident's care planning process. Care plans will be available to all care staff to guide the care delivery provided according to their level of responsibility. 180 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Moderate	Throughout the first day of audit in this facility, residents who were in the lounge looked uninspired and disinterested as there was minimal inclusion in activities for them. The second day was a Friday and because the usual activities coordinator does not work Fridays, the activities coordinator from the sister facility of Granger House led the activities. According to staff, there is not usually a replacement. Residents were involved in making and watching the putting together of floral corsages, then had an entertaining singing and music session, followed by a 'Happy Hour'. The demeanour of the residents was different and they showed interest. Three commented on how 'different' the day was from usual and one volunteered that they had had a fun day. Two different sets of relatives visiting commented on how 'alive' the residents all were. Staff reinforced the change and commented on the physical involvement of a person who struggles to walk. The usual activities coordinator had informed that she spends considerable time doing one on one conversations with some people who do not leave their room very often and this was evident in the activity plan and in residents' records. However, there was evidence in the monthly activities plan, attendance records and evaluations that	Activities are planned and a limited programme provided, however these are not ensuring a variety of options and nor do they all help to develop and maintain strengths, skills and interests that are meaningful to the residents.	Implement an activities programme that develops and maintains strengths, skills and interests that are meaningful to the residents. 90 days

		the activities overall lack variety and are not necessarily meaningful to the residents, as is required by the standard and the ARRC agreement. Monthly activity plans are repetitive; however three previous records show that not all activities eventuate and this was reported as being due to a lack of resources. Family members and five of eight residents informed the planned activities do not interest them or are 'boring', so they do not attend, and others were more specific with comments that they seldom go outside and there are no longer outings.		
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	Ongoing problems with hot water temperatures throughout the facility had been recorded in recent months. The ED was applying to the local council to convert to gas, and whilst the auditors were on site, the permission for this was verbally agreed to via telephone; however, this is not an easily fixable solution. Variances were recorded facility wide on 26 January during audit. There had been no incidents raised related to water temperatures and staff interviewed were aware of the temperature variances however there was no signage at basins, in shower units to remind staff and residents. Hospital wing: 11 out 16 rooms did not meet the required temperatures, with the highest temperature recorded at 67 degrees Celsius. In the showers, toilets, sluice room, laundry and offices, eight out of 13 areas tested did not meet the required temperatures with recording between 65.8 degrees Celsius and 38 degrees Celsius. Temperatures in the kitchen area met the required temperatures. Rest Home wing: 23 out of 25 rooms did not meet required temperatures, with these ranging between 52.6 to 38.7 degrees Celsius. In the showers, hand-basins in shower areas, hand-basins in toilet areas, sluice room, laundry and kitchen, 15 out of 16 areas did not meet requirements, with temperatures ranging between 75 degrees in the kitchen and 36.7 degrees Celsius. Electrical appliances within the facility did not have a current tagging to demonstrate recent testing. This was evident everywhere throughout the facility with the exception of the kitchen area where	Checking and tagging of electrical equipment and calibration of equipment is not evident in all areas, with the exception of the kitchen. There are ongoing problems with water temperature variability throughout the facility with temperatures ranging between 36.7 to 67 degrees Celsius in resident areas. There is a broken sanitiser.	Ensure all plant and equipment complies with legislation and regulations. 90 days

		they were current. A broken sanitiser has been out of action for a few months. Currently quotes have been received for a replacement; however, one is not reported to be available in the immediate future. A cleaning process is in place to mitigate the infection risk; professional advice was sought for this solution.		
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	PA Low	Surveillance of infections is described within the infection control programme. Going forward a quality consultant will be assisting the organisation to benchmark the data against similar service providers throughout the country, however this has not yet been implemented. Infections were being documented in residents' progress notes and in infection incident reports. Records show that the data is collected, collated and graphs have been developed for the past twelve months. The data has not been analysed to ascertain what interventions may be required to manage the information emerging from the data. For example, there was no intervention in relation to a spike in urinary tract infections in December 2016, and there was no explanation available for its occurrence.	Data around the incidence of infection is being collected and collated. Results of surveillance, conclusions and specific recommendations to assist in achieving infection reduction and prevention outcomes are not currently occurring.	As described in the documented infection control programme, infection related data is analysed and specific recommendations are made for the ongoing prevention and control of infections. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.