

Agape Care Limited

Introduction

This report records the results of a Surveillance 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 Health and Disability Auditing New Zealand 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:	Agape Care Limited
Premises audited:	Milton Court Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 29 June 2015 End date: 30 June 2015
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:	32

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

Milton Court is privately owned and has been operated by the current owners for the past six years. The service provides dementia and rest home level care for up to 36 residents. On the day of audit there were 32 residents. One owner has a background in business finance and is responsible for health and safety and building maintenance. The other owner is the manager (registered nurse) with a current practicing certificate. Environmental improvements since previous audit include on-going refurbishments to the interior of the facility and completion of exterior painting.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed three of three previous certification findings around family notification, resuscitation status and timely clinical assessments post incidents.

The service has addressed the one partial provisional audit finding relating to call bells in the dementia care unit.

This audit identified further improvements required around compulsory training, orientation, assessments, care planning, interventions, medication documentation, activity plans, food dates and temperature monitoring and maintenance of corridor carpets.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service practices open communication with residents and families. Concerns are managed and a complaints register has been maintained. There is documented evidence of relative notification for any changes in health status.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Milton Court has implemented a quality and risk management system that supports the provision of clinical care. The service has a strategic business plan. There are annual quality activities that have been reviewed regularly. Quality data is collated for infections, accident/incidents, concerns and complaints. Annual surveys have been collated. There is an internal audit programme.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is a two yearly education programme covering relevant aspects of care. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurse is responsible for each stage of the provision of care. Residents and family interviewed state they are involved in the care planning process. Care plans and evaluations are developed within the required timeframe or earlier as required due to health changes. Resident files include notes by the GP and allied health professionals.

There are separate activity programmes for the rest home and dementia wing that are resident focused. The programmes provide a variety of activities including entertainment and outings to meet the interests and abilities of the consumer group. Community links are maintained.

Medication policies and procedures are in place to guide practice. Education and medication competencies were completed by all staff responsible for administration of medicines. The medication charts reviewed include documentation of allergies and intolerances.

All meals and baking is prepared and cooked on site. Residents' nutritional needs have been identified and choices accommodated. The menu is reviewed by a dietitian. There are nutritious snacks available over 24 hours.

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.
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Milton Court has a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has policies and procedures to appropriately guide staff around consent processes and the use of enablers. The registered nurse is the restraint coordinator. There are currently no residents using enablers or restraint. Staff receive training in restraint and managing challenging behaviour.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (owner/manager - registered nurse) is responsible for the collation of infections. There are policies and guidelines in place for the definition and surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	12	0	3	5	0	0
Criteria	0	36	0	4	5	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Advance directives sighted where applicable for dementia care and rest home residents evidence general practitioner discussion with the family/EPOA and have been signed appropriately. The previous finding around advance directives has been addressed.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	FA	<p>There is a complaints policy to guide practice which aligns with right 10 of the Code. The owner/manager leads the investigation of concerns/complaints in consultation with the registered nurse. Concerns/complaints are discussed (as appropriate) at the monthly staff meeting as sighted in the meeting minutes. The Code of Rights posters, complaints forms and advocacy brochures are visible at the main entrance. There have been three complaints since the previous audit. Two internal complaints have been managed appropriately. One external complaint lodged with the district health board (DHB) has been fully investigated, unsubstantiated and closed off. A</p>

<p>understood, respected, and upheld.</p>		<p>complaints log is maintained.</p> <p>Residents and families interviewed were aware of the complaints process and state management are very approachable. Management operate an “open door” policy.</p> <p>D13.3h. a complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. Seven incident forms for the month of May 2015 were reviewed and identify that family were notified following a resident incident. The RN and the manager confirm family are kept informed on all their relatives’ health changes/needs. Family interviewed confirm they are notified promptly of any incidents/accidents. The previous finding around family notification has been addressed.</p> <p>There is access to an interpreter service. Resident meetings are held three monthly and family are invited to attend. Residents interviewed (four rest home) and families interviewed (three dementia care and one rest home care) state they are kept informed on facility matters and services provided. Residents and families have the opportunity to provide feedback on the services.</p> <p>D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.</p> <p>D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement</p> <p>D16.4b: There is documented evidence of family notification when their relatives health status changes.</p> <p>D11.3: The information pack is read for those with visual impairment and translated to residents as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Milton Court provides rest home level of care for up to 16 residents and dementia level of care for up to 20 residents. On the day of audit there were 13 rest home residents and 19 residents at dementia level of care (including a younger person). The younger person is currently being re-assessed for aged care funding.</p> <p>The joint owners purchased the facility in 2009. One owner has a background in business finance and is responsible for health and safety and building maintenance. The other owner is the manager (registered nurse) with a current practicing certificate and is actively involved in the daily operations of the rest home. The manager supports and mentors the full-time RN and shares the on-call requirement.</p> <p>There is a strategic business plan in place for 2015 with documented goals including (but not limited to); formal documentation of clinical management meetings, involving family in the completion of more comprehensive Life Story for residents, full implementation of InterRAI assessments and ongoing refurbishment and upgrading of</p>

		<p>bedrooms and communal areas including replacement of carpets as required.</p> <p>The owners have reviewed the 2014 business plan. Achievements in 2014 included the reconfiguration of beds to increase dementia level beds and reduce rest home bed numbers. Environmental improvements include the renovation of the dementia unit's second dining/lounge area, replacement of carpet to vinyl in areas as needed, and exterior painting.</p> <p>ARC D17.3di, The owner/ manager has attended at least eight hours of education relating to managing a rest home including aged care provider meetings. The owner/manager (RN) has attended on-site education, current first aid certificate and has attended InterRAI training with two assessments yet to complete.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The service has a quality and risk management plan that describes Milton Court quality improvement processes. The plan identifies objectives, aims, timeframes and assigned responsibilities. Progress is monitored through the staff meetings and from input from the management team (owners, RN and care supervisor).</p> <p>Meeting minutes have been maintained and staff are expected to read the minutes. Quality data is collected and discussed at staff meetings including infections, accidents/incidents, health and safety, internal audits and outcomes and any concerns/complaints. Staff interviewed (one RN, three caregivers, cook and activity coordinator) confirm quality data is discussed as sighted in the meeting minutes.</p> <p>The internal audit schedule for 2014 has been completed and 2015 audits to date have been completed as scheduled. Areas of non-compliance identified at audits have been actioned for improvement.</p> <p>A resident/relative survey is conducted annually. The survey results from 2014 were collated and respondents were satisfied to very satisfied. A concern regarding missing clothing was identified in the survey results. A quality improvement was actioned and residents and families interviewed confirmed there has been an improvement in the laundry system. The 2015 resident/relative survey is in progress.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies have been reviewed regularly by an external consultant. Staff interviewed confirm they are made aware of new/reviewed policies at the staff meetings.</p> <p>D19.3: There is an implemented Health and safety and risk management system in place including policies to guide practice. The service has a health and safety officer with a defined job description. There is a current hazard register (reviewed January 2014) that identifies hazards for each area of work. Staff complete a hazard identification form for hazards. Staff were able to describe their responsibilities in regards to health and safety and reporting of accident/incidents.</p> <p>D19.2g fall prevention strategies were in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls including the use of sensor mats. Falls risk</p>

		assessments were completed on admission and following falls (link 1.3.5).
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Seven incident forms from May 2015 (one rest home and six dementia care) were sampled. There has been RN notification and clinical assessment completed within a timely manner. The previous finding around timely RN assessments has been addressed. Accidents/incidents were recorded in the resident progress notes. There was documented evidence the family/whānau notified for seven incidents/accidents reported.</p> <p>D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the staff meeting which includes discussion on health and safety, incidents and accidents.</p> <p>D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.</p> <p>Discussion with the owner/manager identified the provider understands their obligation to notify the correct authority in regards to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies to support recruitment practices. Five staff files sampled contained all relevant recruitment documentation. Current practising certificates were sighted for the owner/manager (RN) and fulltime RN. The service has an orientation programme that provides new staff with relevant information for safe work practice. Orientation documentation was not completed for all staff files reviewed. Performance appraisals were up to date in the sample of staff files reviewed.</p> <p>The 2014 and 2015 annual education planner includes clinical and compulsory training requirements. Not all aspects of the programme have been provided. The RN has attended external education including InterRAI training. She has completed five assessments and awaiting confirmation of certification to commence resident interRAI assessments.</p> <p>There are 13 caregivers working in the dementia unit. Five staff have completed the required dementia units, six have been employed less than a year and are progressing through the units and two staff employed less than three months have not yet commenced the training. The owner/manager (RN) is in the final stage of completing the workplace assessor NZQA units.</p>
<p>Standard 1.2.8: Service Provider</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>The nurse manager is full time and covers for the registered nurse on her days off. The part time registered nurse works on Monday, Wednesday and Friday (18 hours). Hours are increased as needed to meet resident needs such as an admission. The RN is on-call 24/7. There are dedicated cleaning and food services staff. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Medications are checked on delivery against the medication chart. Standing orders are not used. One rest home self-medicating resident has been assessed for self-medication with regular reviews and monitoring in place as per policy. As required medications are dated and timed on administration. Ten medication charts were sampled and all charts had photo identification and allergy status identified. All ten medication charts have been reviewed by the GP at least three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>The service employs a cook from 7am-1pm daily and an afternoon kitchen hand from 4pm to serves the evening meal. The cook (interviewed) has been in the role 12 months and has had previous experience in the food industry. The cook and kitchen hand have completed food safety and chemical training. There is a rotating three weekly summer and winter menu that has been reviewed by a dietitian. The kitchen is located adjacent to the dementia unit and meals are served directly to the residents. Meals are plated with heated lids and taken by trolley to the rest home dining room. Meals were observed to be well presented and staff were observed assisting resident with their meals and fluids as needed. The cook and staff are aware of resident likes, dislikes and any special dietary requirements. Resident dietary profiles are received for new admissions and there was evidence of six monthly reviews.</p> <p>Residents/relatives interviewed are complimentary of the meals and have the opportunity to feed back on the meals at resident meetings. Nutritious snacks such as sandwiches, yoghurts and desserts are available after hours for dementia and rest home residents.</p> <p>A number of food safety regulations regarding dates and monitoring were not found to be in place on the day of audit.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>The scope of the audit was extended to include this standard, based on the files reviewed. Information gathered on admission from discharge summaries, referral letters, medical notes, and from discussion with the resident/family is used to develop the initial assessment care plan and the first resident long term care plan. Risk assessment tools are available for use on admission and reviewed six monthly however pain assessments had not been completed for residents' who identified pain. Three out of five (two dementia and one rest home) did not have pain assessments for identified pain. The registered nurse has completed interRAI training.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>The scope of the audit was extended to include this standard, based on the files reviewed. Care plans reviewed demonstrated service integration and included input from allied health practitioners. Interventions were not sufficiently documented to support the needs of all residents.</p> <p>A shortfall was identified around the use of short term plans for short term needs.</p> <p>Documentation of resident/family/whanau involvement in the care planning process was not evident in all files reviewed.</p> <p>E4.3: Long term care plans described behaviour management over a 24 hour period for known behaviours.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Moderate	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP consultation or referral to the appropriate allied health professional. Progress notes record significant events and interventions.</p> <p>D 18.4 Continence products are available and resident files include a urinary continence assessment (where applicable), bowel management, and continence products identified for day and night use. Specialist continence advice is available as needed and the RN on duty could describe the referral process. There are adequate supplies of continent products in all areas. There were five wounds (four minor and one chronic wound) with wound management plans that included wound assessments. Short term care plans were in place for minor wounds. There was evidence of wound care specialist involvement in the chronic wound.</p> <p>Shortfalls have been identified around weight and monitoring of behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p>	PA Low	<p>The activity co-ordinator has been with the service for six years and is employed five hours a day Monday to Friday. A consultant diversional therapist provides advice, guidance and up to date information as required. The activity coordinator attends on-site education sessions and holds a current first aid certificate. There are separate activity</p>

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>programmes with dedicated time for the rest home (1-3pm) and the dementia care residents (9am-12noon). Both programmes are flexible and activities reflect interests and skills that are meaningful to the residents. On the day of audit the residents in the dementia wing are observed to be participating in craft activities. One on one time is spent with individuals such as word searches, reminiscing and reading. Small group activities include knitting jumpers for charity, ball exercises and pet therapy. Rest home residents enjoy group activities, shopping and library outings. Music and entertainment is provided. There are regular church visitors. Festive occasions and theme days are celebrated. There are resources available for staff to use after hours and at the weekends. Review of resident files identified a shortfall around activity assessments and activity plans. Resident/family meetings provide an opportunity for feedback and suggestions on the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The initial care plan is evaluated and the long term care plan developed within three weeks of admission. Four of five resident files evidence evaluation of long term care plans six monthly or earlier as required. One resident (dementia level) has not been at the service long enough for a review. There is a physical examination and medication review completed at least three monthly by the GP or earlier as required for changes to resident health. Short term care plans are evaluated and resolved within a timely manner (link 1.3.5.2).</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>The service displays a current building warrant of fitness which expires on 11 August 2015.</p> <p>Stretched carpet in both the rest home and dementia wing corridors was sighted as a potential slip/trip/fall hazard to residents.</p> <p>ARC D15.3; The RN and care staff stated they had adequate available to deliver safe and timely care including pressure relieving resources, transfer belts, mobility aids, wheelchairs, weigh scales, gloves, aprons and masks.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response</p>	<p>FA</p>	<p>There are calls bells in all rest home and dementia bedrooms, communal showers and communal areas. The previous partial provisional audit finding around call bells in dementia wing bedrooms has been addressed.</p>

during emergency and security situations.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (owner/manager – RN) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported to the staff meetings. Data is displayed in the staff office. Monthly and annual trends are identified and quality initiatives/goals are put in place. Caregivers interviewed confirm infection control and surveillance data is available and discussed at staff meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy (reviewed March 2015) includes restraint procedures. The policy identifies that restraint is used as a last resort. There were no residents with enablers or restraints in use. The RN is the restraint coordinator. Training in restraint and challenging behaviour was last attended by staff August 2014.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Five staff files were sampled (owner/manager, RN, two caregivers and one cook). Four out of five files identified the staff member had completed a staff orientation. Caregivers interviewed believed staff receive an adequate orientation to the service including three days working with a “buddy”.	The full-time RN appointed in October 2014 has not completed a documented orientation to the service.	Ensure the RN completes an orientation package. 60 days
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	PA Low	Clinical staff complete competencies relevant to their role including medication competencies. All newly employed caregivers commence aged care education modules on employment. All staff hold a current first aid certificate. There is a two yearly education plan in place.	Training on open disclosure and complaints has not been offered within the last two years as scheduled on the two yearly planners.	Ensure that staff are provided with all educational requirements as per the facility education plan, including open disclosure and

consumers.				complaints management. 90 days
<p>Criterion 1.3.12.1</p> <p>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.</p>	PA Moderate	The RN and care staff interviewed were able to describe their role in regard to medicine administration. There were no signing gaps on the administration signing sheets for regular medications. Telephone orders are used for weekly Warfarin dosage according to the INR level. Two staff sign the controlled drug register when checking out the medication.	1) Weekly GP telephone orders for warfarin have not been signed by the GP within two working days; 2) There is no evidence of two staff signing the signing sheet for the administration of controlled drugs; and 3) Controlled drugs register has not been consistently checked weekly.	1) Ensure that all GP telephone orders are signed by GP within two working days; 2) Ensure that two care staff sign to confirm the administration of controlled drug medication; and 3) ensure that the controlled drug register stock is checked weekly. 30 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Moderate	All foods sighted in the fridge were dated and labelled. Regular cleaning duties were signed off as completed. The chemicals are stored safely within the kitchen. The cook was observed to be wearing appropriate personal protective clothing. All staff entering the kitchen complied with infection control standards.	1) Meat in the freezer had not been dated upon storage 2) Goods were not dated on opening, 3) Dry goods were not stored in sealed containers 4) Temperature recordings have not been monitored and recorded daily as per protocol for the fridge, freezer and cooked foods.	Ensure all aspects of food storage and monitoring of fridge, freezer and hot foods are monitored as per the facility protocols and food safety regulations.

				30 days
<p>Criterion 1.3.4.2</p> <p>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.</p>	PA Low	<p>A range of risk assessment tools are available for use on admission where applicable including (but not limited to); a) resident dietary profile b) coombes falls risk d) water low pressure area risk assessment, e) continence and bowel f) pain assessment g) wound assessment and h) disturbing behaviour assessment (as applicable).</p>	<p>There were no pain assessments in place for three residents (one rest home and two care dementia) who have identified pain.</p>	<p>Ensure pain assessment tools are completed for all residents who identify pain.</p> <p>30 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>There is documented evidence the resident/family/whanau have input into the care planning process in three of five files sampled. Residents/relatives interviewed confirmed they participate in the care planning process.</p> <p>The care plan format describes the resident support needs and interventions required to achieve the resident/family goals.</p> <p>Short term care plans are required to guide care staff in the delivery of care for short term needs. Care staff interviewed confirm they are kept informed of short term care needs at handovers.</p>	<p>1) Two of two dementia files reviewed did not evidence family input into care planning.</p> <p>2) Interventions required to support the resident goals were not documented in five of five residents sampled for the following: a) a rest home resident who self-medicates; b) a dementia care resident with identified depression; c) a dementia care resident assessed as a high fall risk; and d) no short term care plans in place for two residents (one rest home and one dementia care) requiring short term interventions for skin conditions.</p>	<p>1) Ensure there is documented evidence of family involvement in care planning for dementia care residents.</p> <p>2) Ensure there are documented long term and short term needs that reflect the resident's current health status.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of</p>	PA Moderate	<p>Residents' weight is recorded on admission and monitored monthly. Electronic scales are available for weight</p>	<p>1) There are no documented interventions in place for three residents (two rest home and one</p>	<p>1) Ensure there are documented interventions in</p>

services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		<p>monitoring.</p> <p>Behaviour assessments are completed for residents with challenging behaviour. Behaviour management and interventions were documented in the long term care plan for three of three dementia care files sampled.</p>	<p>dementia) with identified weight loss</p> <p>2) There is no monitoring in place for one dementia resident with altered behaviours as described in progress notes.</p>	<p>place for residents with weight loss</p> <p>2) Ensure there is behaviour monitoring in place for residents with altered behaviours.</p> <p>30 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>A life history is completed by the resident/family/whanau describing their past and present interests, hobbies and community links. Activity plans were in place for three residents (one rest home and two dementia care) that were appropriate to their needs, abilities, skills, interests and cognitive function. Activity progress notes are maintained in the integrated file. Activity attendance sheets are maintained for each resident.</p>	<p>Two out of five resident files reviewed (one rest and one dementia) did not have an activity assessment on admission. The same residents did not have an activity plan in place.</p>	<p>Ensure that all residents have an activity assessment and activity plan in place within the required timeframes.</p> <p>60 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Moderate	<p>There are handrails in all hallways that enable residents to move around the facility safely. Doorways are kept clear of hazards. There are security gates at the entrance of the facility. Entry is by call bell. The keypad number is displayed for visitors and residents to freely exit the facility. There is keypad entry to the dementia wing.</p> <p>There are safe outside areas that are easy to access for residents and family/whanau members. These include outdoor shade, tables and chairs. There is a safe garden and grounds area for dementia residents that can be accessed under supervision (for the resident's safety and wellbeing over the winter months.) There is ongoing</p>	<p>During the tour stretched carpet was sighted in the corridors of both the rest home and dementia wings. The service has identified the potential slip/trip/fall hazard and this is recorded in the safety audit conducted in March 2015 as a corrective action. The stretching of the carpet has been due to the regular use of the vax machine to clean carpet. The owner/manager has received</p>	<p>Ensure that the existing slip/trip/fall hazard due to the stretched carpet is eliminated.</p> <p>30 days</p>

		maintenance and repairs to flooring including replacement of carpet with vinyl in bedrooms and communal areas.	quotes within the last week for either stretching the carpet or replacement.	
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.