

# Oceania Care Company Limited - Victoria Place Rest Home & Hospital

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## 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 Central Region's Technical Advisory Services 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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Victoria Place Rest Home/Hospital and Dementia Care
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 28 January 2016      End date: 29 January 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	49



# Executive summary of the audit

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## 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
Yellow	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
Red	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

Victoria Place Rest Home/Hospital and Dementia Care (Oceania Care Company Limited) can provide care for up to 51 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The business and care manager is responsible for the overall management of the facility and is supported by the regional and executive management team. Service delivery is monitored.

Improvements are required to resuscitation directives, training, continuity of care, management of medications and security of the dementia unit.

## 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 low risk.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. This information is brought to the attention of residents' and their families as this occurs. Residents and family members confirm their rights are met, staff are respectful of their needs and communication is appropriate.

Consent forms are provided and they are given whatever information they require prior to giving informed consent. Time is provided if any discussions and explanation are required.

The business and care manager is responsible for management of complaints and a complaints register is maintained. Complaints are managed as per timeframes in the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

An improvement is required to signing of resuscitation directives.

## 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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Oceania has a documented quality and risk management system that supports the provision of clinical care and support at the service. Policies are reviewed at head office and quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status reports. There is a management system to manage residents' records with a document control process in place. Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators.

There are human resource policies implemented around recruitment, selection, orientation and staff training and development noting that an improvement is required to documentation of training for registered nurses.

Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

## 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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Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a guide for all staff while the long term care plan is developed over the first three weeks of admission. Person centred care plans are reviewed every six months, are individualised and risk assessments are completed. Residents' response to treatment is evaluated and documented. Relatives are notified regarding changes in a resident's health condition.

Activities support residents' interests and strengths. The residents and families interviewed expressed satisfaction with the activities provided by the activities coordinators and the diversional therapist.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. Medication competencies are completed annually for all staff that administer medications.

The facility utilises four weekly rotating summer and winter menus, reviewed by a dietitian. Improvements are required relating to continuity of service delivery and medicines management.

## Safe and appropriate environment

<p>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.</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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All building and plant comply with legislation with a current building warrant of fitness and New Zealand Fire Service evacuation scheme in place. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. One room has been converted from an office to a room able to be used for respite services. The audit has confirmed appropriateness of the room for the purpose intended.

There is a dementia unit that has specifically identified indoor and outdoor areas for residents. An improvement is required to ensure that one of the exit doors to the dementia unit locks in a timely manner.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

## 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 restraint minimisation programme defines the use of restraints and enablers. The restraint register is current. Policies and procedures comply with the standard for restraint minimisation and safe practice. Assessment, documentation and monitoring of care and reviews are recorded and implemented. Restraint risks are identified. Residents using restraints had no restraint-related injuries. Staff members receive adequate training regarding the management of challenging behaviour and restraint use.

## 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.
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The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. Staff education in infection prevention and control is conducted according to the education and training programme and recorded in staff files.

Infections are investigated and appropriate antibiotics are prescribed according to sensitivity testing. The surveillance data is collected monthly for benchmarking. Appropriate interventions are in place to address infections. There are adequate sanitary gels and hand washing facilities for staff, visitors and residents. Staff members were able to explain how to break the chain of infection.

## 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)
<b>Standards</b>	0	45	0	2	3	0	0
<b>Criteria</b>	0	96	0	2	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Residents state that they receive services that meet their cultural needs and they receive information relative to their needs. They state that staff respect their wishes.</p> <p>Staff are orientated on residents' rights when employed by the organisation. Staff were able to explain rights for residents in a way that promotes choice.</p> <p>The posters identifying residents' rights are displayed in the facility.</p> <p>Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. All staff have had training in 2015.</p> <p>Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.</p> <p>The auditors noted respectful attitudes towards residents on the days of the audit.</p>

<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>	<p>PA Low</p>	<p>There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.</p> <p>All resident files identified that informed consent is collected. Interviews with staff confirmed their understanding of informed consent processes.</p> <p>The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discusses informed consent processes with residents and their families during the admission process.</p> <p>The policy and procedure includes guidelines for consent for resuscitation/advance directives. An improvement is required to documentation of advanced directives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service and in information packs provided to residents and family on admission to the service.</p> <p>Staff training on the role of advocacy services is included in training on The Code and this was last provided for staff in 2015.</p> <p>The Health and Disability advocate visits the service during the year as confirmed by the management team.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.</p> <p>Family members in the dementia unit state that they act as advocates for their family member and also for other residents if they identify any needs. They state that the management team appreciates their input.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with</p>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked.</p> <p>Families interviewed confirm they could visit at any time and are always made to feel</p>

<p>their family/whānau and their community.</p>		<p>welcome.</p> <p>Residents are encouraged to be involved in community activities and to maintain family and friends networks. Residents' files reviewed demonstrate that progress notes and the content of care plans include regular outings and appointments with a van able to take residents into the community.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved. Evidence relating to each lodged complaint is held in the complaint's folder. Three complaints reviewed in 2015 indicate that the complaints are investigated promptly with the issues resolved in a timely manner.</p> <p>The business and care manager is responsible for managing complaints and residents and family state that these are dealt with as soon as they are identified. Residents and family members state that they have laid complaints in the past with the business and care manager and they feel that they are listened to, with issues resolved.</p> <p>There have been no complaints lodged with the Health and Disability Commission or other external authorities since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The business and care manager, clinical manager or a registered nurse discusses the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code can also be held at the resident meetings, as sighted in the 2015 meeting minutes reviewed. Residents and family interviews confirm their rights are being upheld by the service. The information pack includes information around rights and this can be produced in a bigger font, if required.</p> <p>Information is given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and family members are able to describe their rights and advocacy services particularly in relation to the complaints process.</p>
<p>Standard 1.1.3: Independence, Personal</p>	<p>FA</p>	<p>The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and</p>

<p>Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessments gain details of people's beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident.</p> <p>The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings.</p> <p>Health care assistants report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families confirm that residents' privacy is respected.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports for 2015 or on the incidents reviewed in residents' files. Residents, staff, family and the general practitioner confirm that there is no evidence of abuse or neglect. Staff interviewed were aware of the need for them to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.</p> <p>Resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>The organisation has a cultural responsiveness policy which outlines the processes for working with people from other cultures. Specifically a Māori health policy outlines how to work with Māori and the relevance of the Treaty of Waitangi. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan.</p> <p>Staff who identify as Māori are able to provide support for Māori residents and their families if needed. Staff report that specific cultural needs are identified in the residents' care plans. The business and care manager states that a kaumātua can be accessed by the service to support them on tikanga protocols and general advice.</p>

		Staff are aware of the importance of whānau in the delivery of care for the Māori residents.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies each resident's personal needs from the time of admission. This is achieved with the resident, family and/or their representative. There is a culture of choice with the resident determining when cares occur, times for meals and choices in meals and activities. Staff work to balance service delivery, duty of care and resident choice.</p> <p>Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the resident's cultural values and beliefs. This information is used to develop a care plan.</p> <p>Staff are familiar with how translating and interpreting services can be accessed. Residents in the service did not require interpreting services. Residents who identify as Pacific or Asian state that they receive services that meet their cultural needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility implements the Oceania policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed state that they are aware of the policies and are active in identifying any issues that relate to the policy.</p> <p>Residents and family state that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination.</p> <p>Job descriptions include: responsibilities of the position; ethics; advocacy and legal issues with a job description sighted in staff files reviewed relevant to the role held by the staff member. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the health care assistants' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Victoria Place Rest Home/Hospital and Dementia Care implements Oceania policies to guide practice. These policies align with the health and disability services standards and are reviewed bi-annually. A quality framework supports an internal audit programme. Benchmarking occurs across all the Oceania facilities.</p>

		<p>There is a training programme for all staff and managers are encouraged to complete management training. There are monthly regional management meetings.</p> <p>Residents and families expressed a high level of satisfaction with the care delivered.</p> <p>Consultation is available through the organisation's management team that includes registered nurses, the clinical and quality manager, regional manager and a dietitian.</p> <p>The dementia unit is a small unit and allows for staff to spend time with residents.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms.</p> <p>Family contact is recorded in residents' files. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member and could attend the resident meetings.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. Those reviewed are signed on the day of admission.</p> <p>Family of residents in the dementia unit state that they can raise any issues on behalf of their family and believe that these are followed up promptly.</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>	FA	<p>Victoria Place Rest Home/Hospital and Dementia Care is part of the Oceania Care Company Limited with the executive management team including the chief executive, general manager, regional manager, operations manager and clinical and quality manager providing support to the service.</p> <p>Communication between the service and managers takes place on at least a monthly basis with the clinical and quality manager providing support during the audit. The monthly business status report provides the executive management with progress against identified indicators. The operational and business brief is reviewed as issues identified in the brief have been resolved.</p> <p>There is a clear mission, values and goals. These are communicated to residents, staff and</p>

		<p>family through posters on the wall, information in booklets and in staff training provided annually.</p> <p>The facility can provide care for up to 51 residents with 44 beds identified as dual purpose beds (hospital and rest home) and a seven bed dementia unit. During the audit there were 49 residents living at the facility including 23 residents requiring rest home level of care, 20 residents requiring hospital level of care and six residents in the dementia unit. Two residents were identified as young people with disability requiring hospital level care.</p> <p>The business and care manager (registered nurse) is responsible for the overall management of the service and has been in the role for 19 months. The business and care manager has 15 years aged care experience and 10 years of management experience.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>In the absence of the business and care manager, the clinical manager is usually in charge with support from the regional operations manager and clinical and quality manager (organisational). The clinical manager resigned in January 2016 and the business and care manager who is a registered nurse is acting in the role. The business and care manager is acting in the role of clinical manager. There is also a senior registered nurse who has been with the service for three years who is supporting the business and care manager.</p> <p>HealthCERT has been informed of the temporary appointment of the business and care manager as the acting clinical manager.</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>	FA	<p>Victoria Place Rest Home/Hospital and Dementia Care uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to evidence that they have read and understood. The policy around pressure injuries has been updated and the new policy ratified and sent to the service. The registered nurse confirms that they have read and understood the policy.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an</p>

		<p>internal audit programme. The corrective action plans are documented and evidence resolution of issues completed. There is documentation that includes collection, collation, and identification of trends and analysis of data. Internal audits around pressure injuries are completed, with evidence of discussion around any issues identified.</p> <p>Monthly meeting minutes including quality improvement, staff, registered nurse and health and safety evidence communication with all staff around all aspects of quality improvement and risk management. There are also at least two monthly resident meetings that keep residents informed of any changes. Staff report that they are kept informed of quality improvements. The service has trialed having family meetings particularly for family in the dementia unit, however these were not well attended and have been discontinued. Family are able to come to the resident meetings if they wish.</p> <p>The satisfaction survey for family and residents in 2015 shows a high level of satisfaction and this was confirmed by residents and family interviewed.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly with a facility health check completed quarterly by the clinical and quality manager. Any issues are identified, a corrective action plan put in place and evidence of resolution of issues.</p>
<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>	<p>FA</p>	<p>The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, sentinel events, notification of a pressure injury, infectious disease outbreaks and changes in key managers. The Ministry of Health and district health board have been notified of any sentinel events and of changes in management roles.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and are able to describe the importance of recording near misses.</p> <p>Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place.</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>	<p>PA Low</p>	<p>The registered nurses and the acting clinical manager hold current annual practising certificates along with other health practitioners involved with the service.</p> <p>Staff files include appointment documentation including: signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal.</p> <p>All staff complete an orientation programme and health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Health care assistants confirm their role in supporting and buddying new staff. A new staff member interviewed confirming that they had a comprehensive orientation programme.</p> <p>Annual competencies are completed by clinical staff including hoist, oxygen use, hand washing, wound management, medication management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower. Evidence of completion of competencies is kept on staff files.</p> <p>The organisation has a mandatory education and training programme with an annual training schedule documented. Staff attendances are documented for internal training provided with some registered nurses and health care assistants attending. There is a list of training provided by clinical staff at the district health board, however attendance records require improvement. Education and training hours are at least eight hours a year for each staff member. Two staff have interRAI training and staff have completed training around pressure injuries in 2015.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.</p> <p>There are 45 staff, including clinical staff, staff who facilitate the activities programme and household staff. There is always a registered nurse on each shift. The business and care manager and clinical manager are on call.</p> <p>Residents and families interviewed confirm staffing is adequate to meet the residents' needs.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information could be accessed in a timely manner.</p> <p>Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including their designation.</p> <p>Resident files are protected from unauthorised access by being locked away in an office.</p> <p>Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder with medication. Staff state that they read the long term plans at the beginning of each shift and are informed of any changes through the handover process.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The residents' entry into the service is facilitated in a competent, equitable, timely, and respectful manner. Information packs are provided for families and residents to the hospital, rest home and the dementia unit, prior to admission. The facility requires all residents to have needs assessment service coordinators (NASC) assessments, prior to admission, to ensure they are able to meet the resident's needs.</p> <p>Interviews confirm that the registered nurses (RNs) admit new residents into the facility. Evidence of completed admission records was sighted. The RNs receive hand-over from the transferring agency, for example, the hospital, and utilise this information in creating the appropriate person centred care plan for the resident.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family. There are documented policies and procedures to ensure exit, discharge, or transfer of residents are undertaken in a timely and safe manner. The ACM reported that they include copies of the resident's records including: GP visits; medication charts; current long term care plans; upcoming hospital appointments; and other medical alerts, when a resident is transferred to another health provider.</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>Medicine management policies and procedures are in place and implemented, including processes for safe and appropriate prescribing, dispensing and administration of medicines. The medication areas are free from heat, moisture and light, with medicines stored in original dispensed packs, in a secure manner.</p> <p>Medicine charts list all medications the resident is taking, including name, dose, frequency and route to be given. All entries are dated and allergies recorded. All residents have photo identification. Discontinued medicines are identified. The three monthly GP reviews were not all completed within the three monthly timeframe and some of the charts that were reviewed were not documented as reviewed. Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored daily.</p> <p>Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. Sharps bins were sighted. Unwanted or expired medications are collected by the pharmacy. Medication administration was observed during lunch time in the rest home and the dementia unit. The staff members checked the identification of the residents, completed cross checks of the medicines against the script, administered the medicines, and then signed off after the resident took the medicines.</p> <p>Staff are authorised to administer medications, competencies were reviewed by the lead auditor on the days of audit. This requires completion of medication competency testing, in theory and practice. All staff members responsible for medicines management complete annual competencies. There were no residents who self-administer medicines. Medicines management training occurs for staff.</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>FA</p>	<p>The food service policies and procedures are appropriate to the service setting, with seasonal menus reviewed by a dietitian. Residents' dietary profiles are developed on admission, and reviewed six monthly, or when resident's condition changes. There are current residents' dietary profiles in residents' files and copies in the kitchen. The kitchen staff are informed if resident's dietary requirements change. Interviews with kitchen staff confirm their awareness of the residents' dietary requirements. Kitchen staff are trained in safe food handling processes. Food safety procedures are adhered to.</p> <p>Residents who require special dining aids are provided for, to promote independence. The residents' files demonstrated monthly monitoring of individual resident's weight. Supplements are provided to residents with identified weight loss. In interviews, residents stated they are satisfied with the food service. Residents reported their individual preferences are met and adequate food and fluids are provided. The residents' meeting</p>

		<p>minutes' evidence feedback about the food service is positive. The service provides additional food over a 24 hour period for residents with dementia.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>The service has a documented process for the management of declining resident's entry into their care. Records of enquiry are maintained and in the event of decline, information is given regarding alternative services and the reason for declining services.</p> <p>The scope of services provided is identified in the admission agreement and communicated to prospective residents and their families. The acting clinical manager (ACM) assesses the suitability of residents and uses an enquiry form, with appropriate questions regarding the specific needs and abilities of each resident.</p> <p>When residents are not suitable for placement at the service, the family and / or the resident are referred to other services, depending on their level of needs.</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 Moderate	<p>The RNs or the acting clinical leader complete a variety of risk assessment tools on admission. The service completes interRAI assessments for new residents.</p> <p>Additional assessments were sighted in the residents' files including; the medical assessment completed by the GP and recreational assessment completed by the diversional therapist (DT) and activities coordinator (AC). Baseline recordings are recorded for weight management and vital signs with monthly monitoring.</p> <p>The needs, support requirements, and preferences are collected and recorded for most residents, however one of the residents did not have their needs met in a timely and appropriate manner (refer to 1.3.3.3 rest home tracer).</p> <p>Staff interviews confirmed that the families are involved in the assessment and review processes. The outcomes of the assessments are used in creating an initial care plan, the long term care plan, and a recreational plan, for each resident.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</p>	FA	<p>The person centred care plans (PCCP) are resident focused and integrated. The residents' files have sections for the resident's profile, details, observations, PCCPs, monitoring and risk assessments. Interventions sighted were consistent with the assessed needs and best</p>

<p>consumer focused, integrated, and promote continuity of service delivery.</p>		<p>practice (refer to criterion 1.3.4.2). Goals are realistic, achievable and clearly documented. The service records intervention for the achievement of the goals.</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>	<p>FA</p>	<p>Residents' receive adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions are documented for each goal in the PCCPs. Multidisciplinary meetings are conducted to discuss and review long term care plans. Residents' files reflect residents and family involvement in the development of goals and review of care plans.</p> <p>Interview with the GP confirmed clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long term care plans such as: the speech language therapist; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist.</p>
<p>Standard 1.3.7: Planned Activities</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>FA</p>	<p>The activities programmes confirm that independence is encouraged and choices are offered to residents. The diversional therapist (DT) and activities coordinator (AC) develop and implement the activity programmes. The service had two residents under the age of 65 at the time of the audit.</p> <p>Activities include: physical; mental; spiritual and social aspects of life, to improve and maintain residents' wellbeing. During the onsite audit, activities included: residents going for an outing; music; and one-on-one activities. Residents and family confirm they are satisfied with the activity programmes.</p> <p>On admission, the DT or AC completes a recreation assessment and plan for each resident. Residents' files reviewed during the onsite audit had six monthly activity reviews completed. Residents in the dementia unit have 24 hour activity care plans for managing challenging behaviours, on file.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents' files reviewed showed long term care plans had six monthly reviews completed. Clinical reviews are documented in the multidisciplinary review (MDR) records, which include input from the GP, RNs, HCAs, the DT, AC and other members of the allied health team.</p> <p>Progress notes are completed at every shift by the HCAs and RNs. Progress notes reflect response to interventions and treatments. Residents are assisted in working towards goals.</p>

		Short term care plans are developed for acute problems, for example: infections; wounds; falls; and other short term conditions.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The ACM stated that residents are supported in access or referral to other health and disability providers. The RNs manage referrals for residents to the GP, dietitian, physiotherapist, speech language therapist and mental health services. The GP confirmed involvement in the referral processes. The review of residents' files included evidence of recent external referrals to the physiotherapist and specialists.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage.</p> <p>Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example: goggles/visors; gloves; aprons; footwear; and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Moderate	<p>A current building warrant of fitness is displayed – expiry date August 2016. There have been no building modifications since the last audit although there has been refurbishment of rooms.</p> <p>There is a planned maintenance schedule implemented. The following equipment is available: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There is an annual test and tag programme and this is up to date with checking and calibrating of clinical equipment annually.</p> <p>Interviews with staff and observation of the facility confirm there is adequate equipment.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet and there are</p>

		<p>areas that provide privacy when required. There are internal courtyards and grass areas with shade, seating and outdoor tables.</p> <p>There is a secure unit for residents, identified as requiring this, that includes two entrances with a swipe card access internally and exits into a secure courtyard/garden/grass area which includes shade and seating. One of the entry/exit doors from the dementia unit into the hospital/rest home area closes slowly and an improvement is required.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members report that there are sufficient toilets and showers with some rooms in the rest home/hospital area having their own en-suite.</p> <p>Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. In rooms requiring equipment there is sufficient space for both the equipment, for example, hoists, at least two staff and the resident, with the ability to include emergency equipment in the room if required.</p> <p>Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own.</p> <p>There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.</p> <p>The bedrooms are identified as dual purpose in the rest home/hospital area. Residents requiring hospital level care are clustered together with staff allocated appropriately.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The service has lounge/dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>The dining areas have ample space for residents. Residents can choose to have their meals in their room.</p> <p>The dementia unit has its own dining room and lounge area, with residents in the dementia unit encouraged to join in with activities held in the main hospital/rest home area as observed during the audit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is completed on site, with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry with separate doors to take clean and dirty laundry in and out. Laundry staff are required to return linen to the rooms. Residents and family members state that the laundry is well managed. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. Cleaners were observed to be vigilant on the days of the audit particularly in the dementia unit around keeping the trolley in sight.</p> <p>All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>An evacuation plan was approved by the New Zealand Fire Service in August 2003. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff, six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures.</p> <p>There is always at least one staff member with a first aid certificate on duty with twenty care staff having completed first aid training.</p> <p>All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p>

		<p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency, including food, water, blankets, emergency lighting and gas BBQs.</p> <p>An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways and dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells.</p> <p>The doors are locked in the evenings. Staff complete a check in the evening that confirms that security measures have been put in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature.</p> <p>There is a designated external smoking area for residents.</p> <p>Family and residents confirm that rooms are maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The infection control committee has representatives from each area of the service management team. This group meets monthly. There is an infection control programme that was last reviewed in March 2015.</p> <p>When a resident presents with an infection, staff send specimens to the laboratory for sensitivity testing. The GP prescribes antibiotics as per sensitivity, confirmed during interview. The RNs create short term care plans and review the effectiveness of the prescribed antibiotics when the treatment is completed. Infections are discussed during staff meetings, sighted in meeting minutes.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the</p>	FA	<p>There are adequate human, physical, and information resources, to implement the infection control programme and meet the needs of the organisation. Hand washing signs were sighted around the facility to remind staff and residents of the importance of proper hand washing. The facility maintains regular in-service trainings for infection control, including standard precautions, personal protective equipment, cleaning, infectious diseases and hand</p>

needs of the organisation.		washing. Sighted training records are aligned with the training planner.
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	Documented policies and procedures for the prevention and control of infection reflect accepted good practice and relevant legislative requirements and are readily available and implemented at the facility. These policies and procedures are practical, safe and appropriate/suitable for the type of service provided.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The organisation provides relevant education on infection control to all service providers, support staff and residents. The infection control education is provided by either the BCM or external resource speakers. Residents interviewed were aware of the importance of hand washing. Staff members confirmed receiving infection control training and could explain the importance of hand washing in the prevention and control of infection.
<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>The acting clinical manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example, facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.</p> <p>The organisation has an internal benchmarking system. Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the staff meeting.</p>
Standard 2.1.1: Restraint minimisation	FA	Staff interviewed, observations, and review of documentation, demonstrated safe use of restraint or enablers. The service has a policy of actively minimising restraint. The service

Services demonstrate that the use of restraint is actively minimised.		has a documented system in place for restraint and enabler use, including a restraint register. There were five restraints and two enablers being used in the facility. The restraint coordinator is the business and care manager.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint 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.</p>	FA	<p>The facility maintains a process for determining approval of all types of restraints used. The restraint coordinator completes a restraint assessment, which is then discussed with the GP prior to commencement of any restraints. The restraint committee is defined in the restraint minimisation and safety policies and procedures.</p> <p>The duration of each restraint is documented in the restraint plans of residents. HCAs are responsible for monitoring and completing restraint forms when the restraints are in use. Evidence of on-going education regarding restraint and challenging behaviour is evident. Staff members are made aware of the residents using restraints during monthly staff meetings. This was confirmed during staff interviews.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	Restraint assessments include restraint related risks. The service records underlying causes for behaviour that requires restraint with a focus on culturally safe practices, identification of desired outcomes and possible alternatives to restraint. Restraint risks and monitoring timeframes are identified in the restraint assessment records.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	Before resorting to the use of restraint, the restraint coordinator utilises other means to prevent the resident from incurring injury, for example, the use of sensor mats. Restraint consents are signed by the GP, family and the restraint coordinator. Restraints are incorporated in the long term care plans and are reviewed three monthly. The restraint register is up to date. The GP confirmed that the facility uses restraints safely.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint is still required. The family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. Restraint minimisation and safe practices are reviewed.

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The facility demonstrates the monitoring and quality review of their use of restraints. The audit schedule was sighted and included restraint minimisation reviews. The content of the internal audits includes the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff knowledge and good practice was also included in the quality reviews.</p>
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## 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 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	The general practitioner documents competence of a resident to make an advance directive. The resident signs, if competent, to indicate if they wish to be resuscitated or not. End of life information relating to residents unable to make decisions for themselves form is completed when the resident is not competent to document an advance directive. The form includes the ability for the family or enduring power of attorney to identify 'for cardiopulmonary resuscitation or not for resuscitation'(NFR). The form states that 'while the EPOA/family may not make an advance directive on behalf of the resident, they may provide guidance in relation to what this person would have wanted to happen if the service user were dying', however the EPOA's circle the NFR directive which then becomes a 'not for resuscitation' instruction.	Two of the seven files reviewed included directives around not for resuscitation documented by the EPOA or family.	Ensure that 'not for resuscitation' directives are signed only by the resident deemed competent to make the decision.  180 days
Criterion 1.2.7.5 A system to	PA Low	Staff are expected to sign attendance lists to indicate that they have attended training. The attendance lists are kept up to date for internal	While there is a list of attendees at district health	Ensure that registered

identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.		training and are predominantly signed by health care assistants with some training indicating that registered nurses have attended. Clinical staff from the district health board have provided training for registered nurses and this in 2015 has included hydration and nutrition, wound care, pressure injuries and end of life care.	board facilitated training, there is no signed evidence that registered nurses have attended.	nurses sign to indicate that they have completed training.  180 days
Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	The service is using the Medi-Map system for administering medicines. Entries to the system are clear, have photo identification, allergies are recorded, and the system keeps record of discontinued medicines.	Three monthly reviews have not consistently been completed within the three monthly required timeframe and some of the charts that were reviewed were not recorded in the system as having been reviewed.	All medicine chart reviews to be completed at three monthly intervals and the medicines management system to reflect evidence of this having occurred.  90 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	PA Moderate	The service has a variety of processes to identify the needs and outcomes for residents. The assessment processes are documented and forms the basis of the person centred care plan.	A resident developed two pressure injuries, and although the health care assistants (HCA) were aware of the injuries, this was only discovered/reported to the RN twenty days later. Interviews with HCA confirmed a breakdown in communication between	The service to ensure that the needs, outcomes and goals of residents are identified and communicated to ensure continuity of care.

delivery planning.			the HCAs and RNs due to a change in their system.	30 days
<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>	<p>PA</p> <p>Moderate</p>	<p>One of the entry/exit doors from the dementia unit into the hospital/rest home area closes slowly while the other entry/exit door locks immediately on closing. The business and care manager states that an external contractor has attempted to adjust the closing of the door in the past. A tradesman was at the facility on the day of audit working on improving the closing of the door.</p>	<p>One of the entry/exit doors from the dementia unit into the hospital/rest home area closes slowly (up to 10 seconds to lock) with the service having an external contractor to adjust the closing of the door on the day of the audit.</p>	<p>Monitor and document the results of the locking of the entry/exit door from the dementia unit to ensure that the door is locked in a timely and safe manner for residents.</p> <p>60 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.