

Okere House 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 Audit (NZ) 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: Okere House Limited

Premises audited: Okere House

Services audited: Dementia care

Dates of audit: Start date: 17 March 2016 End date: 17 March 2016

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: 19

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

Okere House provides residential care for up to 26 residents who require dementia level rest home care. Occupancy was 19 during this audit. The governing body is Okere House Limited.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with a resident, families, management, staff and a general practitioner.

Four of the five areas identified as requiring improvement during the last audit have been addressed. The one remaining area requiring improvement relates to resident documentation. One new area was identified as requiring improvement during this audit relating to practising certificate for one of the registered nurses.

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.
--	--	--

Staff demonstrate an understanding of residents' rights and obligations. Information regarding residents' rights, access to interpreter services and how to lodge a complaint is available to residents and their families. The facility manager is responsible for the management of complaints and a complaints register is maintained. There has been one complaint investigation undertaken by the DHB since the last certification audit.

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.
---	--	---

Okere House Limited is the governing body and is responsible for the service provided at Okere House. Business and quality plans were reviewed along with a philosophy, mission statement, scope of service, values and business and quality goals. The facility manager meets with the director monthly.

The facility manager is supported by two registered nurses (RNs); one of which has recently graduated.

The service continues to make ongoing improvements with management of the quality and risk management systems. The two areas identified during the last audit as requiring improvement relating to quality and risk management documentation have been addressed. Quality indicators are reported monthly to staff. There is an internal audit programme and audits are completed. Risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, infection control surveillance, accident/incident forms, meeting minutes and surveys evidence analysis of data and the development of corrective action plans to address any issue/s that require improvement.

There are policies and procedures on human resource management. Staff files evidence job descriptions, orientation, performance appraisals, and police vetting. With the exception of the recently graduated RN, current practising certificates are held on files for all health professionals who require them to practice.

An in-service education programme is provided for staff at least monthly. Caregivers are also supported to complete the New Zealand Qualifications Authority Unit Standards relating to aged care and dementia; staff have either completed the dementia specific education modules or are working towards completing them.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The facility manager and the registered nurses are available on call after hours. Care staff interviewed reported there is adequate staff available.

Continuum of service delivery

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

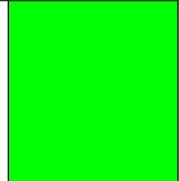
Residents' needs are assessed on admission. The residents' files provide evidence that needs, goals and outcomes are identified and reviewed on a regular basis; however the assessment is not always undertaken using the interRAI assessment tool and this requires attention. A previous corrective action around the organisation not meeting timeframes for GP visits has been addressed. Interviews with residents' families reported being well informed and involved, and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities available and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with access to food at any time, special dietary requirements and need for feeding assistance or modified equipment met. Observation at meal times and interviews verified satisfaction with meals.

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.		Standards applicable to this service fully attained.
--	---	--

The improvements required during the last audit relating to calibration/performance verification of biomedical equipment have been made.

A current building warrant of fitness is displayed.

Restraint minimisation and safe practice

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

The organisation has processes in place for determining safe and appropriate restraint and enabler use and reflects the requirements of the restraint minimisation and safe practice standard. On the day of audit the restraint register was up to date. The care staff demonstrate knowledge and understanding of safe restraint management processes, including enabler 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.

Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. A previous corrective action requiring the infection control nurse to attend ongoing infection control training has been addressed. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the infection control programme. Data on the nature and frequency of identified infections is collated and analysed. The results of surveillance are reported through all levels of the organisation.

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	16	0	2	0	0	0
Criteria	0	40	0	2	0	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The facility manager is responsible for the management of complaints. There are appropriate systems in place to manage the complaints processes. The last complaint documented in the complaints register was received in March 2016 and was made by a resident. The complaint relates to allegations of abuse of a resident by a staff member. This complaint was investigated and the staff member is no longer working at Okere House. There has been one complaint investigated by the DHB since the last audit and one aspect of this complaint relating to an aspect of care has been substantiated. The DHB is continuing to address other aspects of this complaint that relates to a DHB process.</p> <p>The facility manager advised there have been no investigations by the Ministry of Health, Health and Disability Commissioner, Accident Compensation Corporation (ACC), Coroner or Police since the previous certification audit.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Systems are in place that ensure residents and their families are advised on entry to the facility of the complaint processes. Family members demonstrated an understanding and awareness of these processes. Family members and residents are able to raise any issues during the family and resident meetings. Family members interviewed and review of meeting minutes confirmed this. Review of the collated family survey completed in February 2016 evidenced family knew the process for making a complaint.</p>

		The complaint process and forms were observed to be readily accessible and displayed.
<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>A review of accident/incident forms showed timely and open communication with residents/family members. Communication with family members is recorded in the resident's file. Family members expressed satisfaction with how well they were kept informed about any change to the resident's condition and their involvement in resident care planning. Family and residents' meetings are held monthly and minutes were reviewed.</p> <p>The facility manager advised that interpreters are able to be accessed from: the district health board (DHB) interpreter services; the local community; or family members if required. This information is also provided to residents/families as part of the information/admission pack.</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>Okere House Limited is the governing body and is responsible for the service provided at Okere House. Business and quality plans were reviewed that include business and quality goals as well as scope of service, vision, values and philosophy of care. The director visits Okere House monthly and reviews progress towards meeting the goals as well as service delivery during these visits.</p> <p>The facility manager, who is not a registered nurse, is supported by two registered nurses (RNs) who are responsible for oversight of clinical care. The RNs each have been allocated different areas of responsibility and these were reviewed in their personal files. Registered nurse (RN) cover is provided six days a week between 7am and 4.00pm as well as after-hours via an on-call roster shared between the two RNs. The facility manager has a diploma in business and was appointed to this position in April 2014.</p> <p>The facility manager and the registered nurses' personal files and education records were reviewed and provided evidence of maintaining knowledge and current practice.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>Okere House Limited is certified to provide 26 dementia level care beds and 19 of these beds were occupied during this audit. The service provider has funding contracts with the district health board (DHB) to provide aged related residential care (dementia), carer relief / residential respite, and long term support - chronic health conditions. There were two residents aged less than 65 years of age and assessed as requiring dementia level care.</p>
Standard 1.2.3: Quality And	FA	The two areas identified as requiring improvement during the last audit relating to quality and risk

<p>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>management systems have been addressed.</p> <p>A quality improvement plan is used to guide the quality programme and includes goals and objectives. An internal audit programme is in place and internal audits completed in 2015 and 2016 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk.</p> <p>Monthly quality/leadership, staff and family and resident meetings are held. Meeting minutes were reviewed and these are available for review by staff. Meeting minutes provide evidence of reporting/ feedback on completion of internal audits and various clinical indicators.</p> <p>The facility manager is responsible for ensuring the organisations quality and risk management systems are maintained.</p> <p>Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed and reported. Quality improvement data reviewed, including adverse event forms, internal audits and meeting minutes provided evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service and reference legislative requirements. Policies/procedures are available with systems in place for reviewing and updating the policies and procedures. Staff confirmed during interviews they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p> <p>The health and safety policies and procedures are available and staff are aware of and report hazards at the facility, when this is required. Chemical safety data sheets are available.</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</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the registered nurse/s and the facility manager and are signed off when completed. Corrective action plans to address areas requiring improvement are documented on accident/incident forms. The registered nurse undertakes assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate. The facility manager, registered nurses and care staff reported the registered nurse on call is contacted if a resident has an unwitnessed fall when the registered nurse is not on duty.</p> <p>Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they complete accident/incident forms for</p>

<p>open manner.</p>		<p>adverse events. Policy and procedures comply with essential notification reporting for example health and safety, human resources, infection control.</p> <p>The facility manager reported they are aware of their responsibilities concerning essential notifications and evidence of this was reviewed during audit including the three section 31 notifications of reportable events made to the Ministry of Health in 2015.</p> <p>Residents' files reviewed as well as accident and incident forms, residents' progress notes, and family communication sheets provided evidence that communication/contact with family is being documented following adverse events (as appropriate) involving the resident, or when there is any change in the resident's condition. Family members advised they are contacted if their family member has an accident/incident, and/or if there is any change in their condition. This finding was confirmed during review of the satisfaction surveys.</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>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, and police vetting and completed orientations. One of the two RNs does not have a current practising certificate (see criterion 1.2.7.2). Copies of annual practising certificates were reviewed for the rest of the staff and contractors that require them to practice.</p> <p>The facility manager, with support from the registered nurses, is responsible for management of the in-service education programme. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided. The two RNs have the required interRAI assessments training and competencies.</p> <p>In-service education is provided at least twice a month. Care staff are supported to complete the New Zealand Qualifications Authority approved aged care education modules including the dementia specific modules. Care staff have either completed the dementia specific education modules or are working towards completing them. Staff are also supported to complete education via external education providers.</p> <p>An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.</p> <p>Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and the currency</p>

		of their performance appraisals.
<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>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided Monday to Saturday. The two registered nurses share the after -hours on call and the on call RN is documented on the roster. The facility manager is also available after hours. The minimum amount of staff on duty is during the night and consists of two caregivers.</p> <p>Care staff interviewed reported there is adequate staff available and that they are able to get through their work. All staff are required to have current first aid certificates. Family members and their representatives reported staff provide the residents with adequate care.</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>	FA	<p>The medication management policy is comprehensive and identifies all aspects of medicine management.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Controlled drugs, when required, are stored in separate locked cupboards. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences accurate records.</p> <p>The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart.</p> <p>There are no residents' who self- administer medications.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The residents' doctor and designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders, specific to each resident, are used and documentation is compliant with guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	FA	<p>The food, fluid and nutritional requirements of the residents are provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented recent assessment of the planned</p>

<p>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>menu.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, were sighted. Food is available and accessible 24 hours per day, to meet residents' needs. Evidence of residents' nutritional requirements being met was verified, by observation, documentation and interviews.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.</p> <p>The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule was sighted as was verification of compliance.</p> <p>Evidence of resident satisfaction with meals is verified by residents' family/whanau interviews, documentation recording residents comments after each meal, sighted satisfaction surveys and residents families meeting minutes.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining room is clean, warm, light and airy to enhance the eating experience.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Click here to enter text</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes. Residents have freedom to move around within an environment that maximised resident safety. Residents' family/whanau members expressed satisfaction with the care provided. Residents' were observed to be having their needs attended to by staff in a calm and relaxed manner. There was no evidence of behaviours that were causing distress to others.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and meet the residents' needs.</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 programme is provided by a trainee diversional therapist, with mentoring input from a qualified diversional therapist.</p> <p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop a twenty-four hour activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.</p> <p>A meeting of residents' family members is held monthly. Meeting minutes, interviews and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered.</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>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews and documentation, verified residents' family/whanau are included and informed of all changes.</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</p>	<p>FA</p>	<p>The improvements identified during the last audit relating to calibration and performance verification of biomedical equipment and scales have been made. Electrical safety tags were viewed on electrical items.</p> <p>A maintenance person is contracted for 20 hours a week. There are planned and reactive maintenance systems in place. Systems are in place for ongoing refurbishment and replacement of equipment.</p> <p>A current building warrant of fitness is displayed that expires on 1 June 2016.</p> <p>A visual inspection of the facility provides evidence of safe storage of medical equipment. Corridors are</p>

purpose.		<p>wide and residents were observed safely passing each other; safety rails are secure and are appropriately located.</p> <p>A secure external area is provided for residents and residents are protected from risks associated with being outside (e.g., provision of adequate and appropriate seating; provision of shade; and ensuring a safe area is available for recreation or evacuation purposes).</p> <p>Care staff interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.</p>
<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	<p>Interviews, observation and documentation verify staff have received education in infection control and prevention at orientation and ongoing education sessions. A previous corrective action requirement for the infection control nurse to have updated training in infection control has been addressed.</p> <p>Resident education and management occurs in a manner that recognises and meets the residents' and the families' communication style, as verified by staff and residents' family interviews.</p>
<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>Surveillance of infections is occurring as per the HDSS IC surveillance guide, and is the responsibility of the infection control nurse.</p> <p>Daily incidents of infections and the required management plan are presented daily at handover, to ensure early interventions. Surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions.</p> <p>Incidents of infections are presented to staff at staff meetings, as evidenced by meeting records, infection control records and staff interviews. Incidents of infections are benchmarked internally. There have been no recent outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. It states that the service aims to minimise the use of restraint and to ensure that if restraint is necessary, to keep the resident safe from harm from both themselves and others and that the practice occurs in a respectful manner. This includes the use of enablers which are voluntary and the least restrictive option to meet the needs of the resident. There was one resident requiring restraint at the time of audit. All appropriate documentation and monitoring schedules were sighted. Interview with the family verified involvement in the restraint approval and review process. A referral has been made for a review of care level for this resident.</p>

		Staff interviews confirm their knowledge and understanding of safe restraint use.
--	--	---

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 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	Copies of practising certificates for GPs, pharmacists and one RN are kept in a folder along with a register of renewal dates. The personal files for both RNs were reviewed and the recently graduated RN, who works three days a week, has a Certificate of Registration dated 16 December 2015, issued by NZ Nursing Council in their file. This RN and the facility manager stated an application for a practising certificate was submitted to Nursing Council the week prior to this audit. The other RN, who works four days a week, has a current practising certificate and a copy of this was reviewed in their personal file.	One of the two registered nurses does not have a current practising certificate.	Provide evidence the recently graduated registered nurse has a current practising certificate. 30 days
Criterion 1.3.3.3	PA Low	One of five residents' files reviewed did not have evidence of an InterRAI assessment completed. An interview with the Registered nurse (RN)	Some aspects of	Provide evidence

<p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>disclosed initial and ongoing interRAI assessments for all residents' have not been completed. A recent change in RNs, accessing interRAI training and timeframes has impacted on this, however now the RNs are all trained in interRAI and a process is in place to address this.</p>	<p>assessment is not provided within the required timeframes.</p>	<p>that all residents have up to date interRAI assessments completed.</p> <p>180 days</p>
---	--	---	---	---

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.