

# Winchcombe Healthcare Limited - Cook Street Nursing Care Centre

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Winchcombe Healthcare Limited
<b>Premises audited:</b>	Cook Street Nursing Care Centre
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 5 July 2016      End date: 6 July 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>	29

# 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
	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

Cook Street Nursing Care Centre provides residential care for up to 30 residents who require hospital and rest home level care. The facility is operated by Winchcombe Health Care Limited.

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

This audit has resulted in a continuous improvement rating relating to the involvement of residents in the wider community, and identified that improvements are required around signing of advance directives, interRAI assessments which are not completed within required timeframes and the menu which has not been reviewed by a dietitian within the past two years.

## 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.
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The service has systems and processes in place to ensure the independence, personal privacy, individual needs and dignity of residents are respected. Staff receive regular training on resident rights and demonstrated good understanding of how to ensure these rights are maintained on a day-to-day basis. There are established systems to ensure the informed consent of residents is obtained. The Maori Health Plan is comprehensive, and this and other policies provide detailed guidance for staff in relation to meeting residents' cultural needs.

The services provided to residents are of an appropriate standard. During the audit visit staff were observed to be interacting with residents in a warm, professional and unhurried manner. Residents and family members advised they were very satisfied with the services provided, and appreciated the approachability of staff.

The organisation respects and supports the right of the resident to make a complaint. The service has a complaints register and the information is recorded to meet the requirements of the Standard.

## 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.		Standards applicable to this service fully attained.
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Winchcombe Health Care Limited is the governing body and is responsible for the service provided. A business plan and a quality and risk management plan were reviewed that included a mission statement, values, quality objectives, strengths and weaknesses.

The facility is managed by an experienced manager who has been in their current position for three years. The facility manager is supported by a nurse manager and a clinical team leader/registered nurse. The nurse manager is responsible for oversight of clinical care provided to residents.

Quality and risk management systems are in place. There is an internal audit programme. An up to date hazard register is in place. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms, and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the

issue/s that require improvement. Staff meetings are held and there was reporting on various clinical indicators, quality and risk issues and discussion of any trends identified. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resources management and current annual practising certificates for health professionals who require them. An inservice education programme is provided for staff and sessions are held at least once a month. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records are maintained. Human resource processes are followed.

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. Registered nurses are on duty at all times. The facility manager and the nurse manager are on call after hours. Care staff reported there are adequate staff available and that they were able to get through their work. Residents and family reported there were enough staff on duty to provide adequate care.

Systems are in place that ensure all aspects of resident information management are consistent with legislative and best practice requirements.

## 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.
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Service delivery for residents is guided by individualised care plans, which reflect the integration of a comprehensive range of clinical information. The input of residents and their families into the development and evaluation of these plans is encouraged.

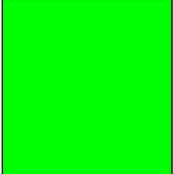
Resident progress notes are updated each shift, and there are well-developed processes in place, such as verbal handovers and communication sheets, to guide continuity of care.

All aspects of medication management comply with legislative and safe practice requirements. Registered nurses are responsible for all medication administration.

Food services staff are qualified and experienced. Food service delivery is well organised, and the kitchen maintained in a clean and hygienic manner. Residents' individual food likes/dislikes are respected and residents reported their enjoyment of the meals. There are two separate dining areas for residents.

An enthusiastic and experienced diversional therapist manages the activities programme. This programme offers residents a variety of individual and group activities, with a strong emphasis on supporting residents to maintain their links with the community.

## 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.
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Winchcombe Health Care Limited is the governing body and is responsible for the service provided. A business plan and a quality and risk management plan were reviewed that included a mission statement, values, quality objectives, strengths and weaknesses.

The facility is managed by an experienced manager who has been in their current position for three years. The facility manager is supported by a nurse manager and a clinical team leader/registered nurse. The nurse manager is responsible for oversight of clinical care provided to residents.

Quality and risk management systems are in place. There is an internal audit programme. An up to date hazard register is in place. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms, and meeting minutes

evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff meetings are held and there was reporting on numbers of various clinical indicators, quality and risk issues and discussion of any trends identified in these meetings. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resource management and current annual practising certificates for health professionals who require them. An inservice education programme is provided for staff and sessions are held at least once a month. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records are maintained. Human resource processes are followed.

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 nurse manager are on call after hours. Care staff reported there are adequate staff available and that they were able to get through their work. Residents and family reported there were enough staff on duty to provide adequate care.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has clear policies and procedures which meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraint and enablers during the audit. Relevant staff education and competency assessment occurs at least annually. The restraint approval committee undertakes regular quality reviews to ensure compliance with policies and to consider all aspects of restraint and enabler use. The restraint/enabler register is current.

## 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.

Effective systems and processes are in place to minimise the risk of infection to residents, visitors and staff. Staff receive ongoing training related to infection control, and have access to a range of personal protective equipment. Infection surveillance is systematic, and surveillance results are effectively communicated to staff.

## 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	47	0	3	0	0	0
<b>Criteria</b>	1	97	0	3	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)
<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>	FA	<p>All staff receive education related to the Health and Disability Commissioner's Code of Health and Disability Services Consumer's Rights (the Code) as part of their orientation. Annual training is also provided for all staff on the Code, as confirmed in staff education records and during staff interviews.</p> <p>Staff interviewed demonstrated a good understanding of the Code, and shared examples of the practical implementation of the Code in their daily work with residents.</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>	PA Low	<p>Each resident, and/or their enduring power of attorney (EPOA), completes a comprehensive consent form at the time of admission. This includes consent for treatment, the taking of photographs, and the release of personal information. The CTL advised that consent is reviewed on an as-required basis, such as when a resident's needs change, or additional medical/surgical treatment is required. Completed consent forms were seen in all residents' records reviewed.</p> <p>Residents and staff interviewed confirmed they were consistently given the opportunity to make informed choices and that their consent was obtained and respected. Family members in particular spoke highly of being kept informed about what was happening with the resident. They were also consulted in situations, such as when consideration was being given to transferring the resident to a public hospital.</p> <p>Current resuscitation/not for resuscitation orders were sighted in all resident records reviewed. Advance</p>

		directive orders were not consistently completed.
<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>	FA	<p>As part of the admission process all residents are given a copy of the Nationwide Health and Disability Advocacy Service (Advocacy Service) brochure. Additional copies of this brochure were also available at reception. Residents and family members confirmed on interview their awareness of the Advocacy Service and how to access this.</p> <p>Information on the Advocacy Service is included in the staff orientation programme and in the ongoing education programme for staff. This was confirmed in staff orientation and training records. On interview, staff demonstrated their understanding of the Advocacy Service, including where to locate the services' list of advocates and interpreters.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has unrestricted visiting hours, and all family members spoken with advised they felt very welcome when they visited. Residents who are well enough are supported to maintain their community interests, and to visit with families and friends. Residents are also supported to access health care services outside of the facility, such as attending hospital clinic appointments or going to the dentist.</p> <p>The diversional therapist also has a number of strategies in place to promote links between the residents and their community. This includes the weekly lunch outing, but also reciprocal visits with a local church which is helping to foster friendships between the church members and individual residents.</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>	FA	<p>The facility manager and the nurse manager are responsible for managing complaints, and there are systems in place to manage the complaints process. A current register is maintained. The two most recent complaints evidenced they were managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and displayed. Quality and Staff meeting minutes evidenced reporting of complaints to staff. Care staff confirmed this.</p> <p>The facility manager advised there have been no investigations by the Ministry of Health, the DHB, the Accident Compensation Corporation (ACC), the District Health Board (DHB), the Police or Coroner, 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 Clinical Team Leader (CTL) outlined the processes that are in place to ensure that residents and/or their families are informed of their rights. This includes providing each new resident and their family with brochures about the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) during the admission process. This is discussed with them at the time of their admission by the CTL or the Facility Manager (FM). There are ongoing opportunities for further discussions with management having an open-door policy. Additional copies of the Code and the Advocacy Service are also available at the entrances to the facility, and also available in poster form. Copies of signed resident rights and responsibilities forms were also sighted in residents' files.</p> <p>Residents and family members spoken with during the audit visit reported they had been given information about the Code and had been given ample opportunities to discuss this.</p>
<p>Standard 1.1.3: Independence, Personal 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>FA</p>	<p>The physical, visual, auditory and personal privacy of residents was respected. All residents have a private room, which they are encouraged to personalise. Staff were observed to knock on closed doors before entering a resident's room and to address residents by their preferred names. Staff were also observed to interact with residents in a pleasant, friendly and unhurried manner.</p> <p>All residents' clinical files were kept in locked cupboards and personal electronic data was password protected. Archived material for both current and former residents was stored securely and privacy of information was maintained during staff handovers.</p> <p>There was evidence in all of the care plans reviewed that these plans had been developed in conjunction with the resident and/or their family. Plans included documentation on each resident's individual cultural, religious and social needs, values and beliefs. Care plans included detailed outlines of residents' abilities, and strategies to promote and maximise their independence.</p> <p>The service's policies related to privacy and dignity, and to abuse and neglect, were understood by those staff interviewed. They were able to provide examples of what would constitute abuse and neglect and the actions they would take if they suspected this. All staff undergo a police check as part of the employment process and staff human resources records confirmed those checks had been completed and that referee checks had also been completed. Staff education related to abuse and neglect was last provided in May 2016.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as</p>	<p>FA</p>	<p>The service currently has one resident who identifies as Maori and their care is guided by a detailed Maori Health Plan 2015-2019. This plan includes policies related to the Treaty of Waitangi, cultural safety and meeting the special cultural needs of Maori in relation to death and dying; a framework for cultural recognition; and a range of strategies (training and education, reduction of barriers, integration of Maori</p>

<p>Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>values and beliefs and cultural practices, availability of staff) to implement the plan. A folder of additional resources is also available to guide staff, together with the names and contact details of specialist advisers who can also be contacted. The CTL advised that the rooms of deceased residents are blessed by a kaumatua prior to the next resident being admitted.</p>
<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>	<p>FA</p>	<p>The services' cultural and spiritual policy guides staff as to how to meet residents' cultural needs. Residents' personal preferences and special requirements were included in all the care plans reviewed, with interventions documented to ensure these were met. There was also evidence in those care plans of the resident and/or their family being involved in their development. During interviews, residents and family members advised they had been consulted about the resident's individual cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>All residents and family members interviewed stated that residents were free from any type of discrimination or exploitation. A doctor and another health professional also confirmed their satisfaction with the standard of services provided to resident, and confidence that residents are not discriminated against or exploited in any way.</p> <p>The CTL advised that education related to all forms of discrimination and exploitation is a component of the orientation for all new staff, and then part of the ongoing education programme provided by the facility. All staff are provided with a copy of the House Rules, and this, together with their individual employment agreements, also provides further guidance for staff. When interviewed, staff were able to demonstrate a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>A range of current policies, reflecting best practice, are available to guide care delivery related to clinical issues, such as pain management, diabetes management and wound care. The NM outlined the process for developing these policies, which includes gathering information from a range of sources, such as Map of Medicine and nursing guidelines, as well as relevant information from the internet. The service has well-established professional networks with a range of specialist providers, such as Elder Health services at MidCentral Health, a dietitian, physiotherapist, and palliative care services, as well as being able to call on the expertise of the doctors who regularly visit the facility. The service also closely monitors the standard of care through monitoring clinical indicators, internal audits and complaints/concerns.</p> <p>On interview, a doctor and another health professional confirmed their satisfaction with the standard of</p>

		care provided to residents. Family members and residents also expressed satisfaction for service delivery standards.
<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>There was clear evidence of open disclosure and effective communication with residents/families noted in all residents' files reviewed. Communication was well documented in family/whanau communication sheets, on the accident/incident form and in the residents' progress notes. The CTL also advised that residents' families were either phoned or contacted by email when there were changes in a resident's condition, and this was confirmed in interviews with family members. Evidence was sighted of resident/family input into the care planning process. The service also invites residents and families to participate in the six-monthly multidisciplinary team meeting held for each resident. Minutes were sighted of the monthly resident meetings.</p> <p>Details of interpreters which the service can access as required were sighted. Staff training records confirmed that training on open disclosure was last held in May 2016.</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>Winchcombe Health Care Limited, the governing body, is a family owned business. Robust systems are well embedded that define the scope, direction and goals of the organisation, as well as the monitoring and reporting processes against these systems.</p> <p>A 'Facility and Organisational Business Plan 2015-2016' includes goals, objectives, a 'SWOT' analyse, mission statement, and philosophy of care. An organisational chart documents lines of responsibility.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service. The facility manager provides a monthly management report to the owner that covers a wide range of topics. Meeting minutes reviewed included a combined quality/staff/restraint/infection control meeting, registered nurse meetings and residents' meetings. Meeting minutes were available for review by staff along with clinical indicator reports and graphs.</p> <p>The facility is managed by a facility manager, who has been in this position for three years and has a diploma in management. The nurse manager who is an experienced registered nurse has been in their position for 18 months and supports the facility manager along with a clinical team leader/RN.</p> <p>Review of the two managers' personal files and interview of the facility manager and nurse manager evidenced the managers have undertaken on-going education in relevant areas.</p> <p>Cook Street is certified to provide hospital level and rest home level care. On the day of this audit there were 19 hospital residents and 10 rest home residents.</p>

<p><b>Standard 1.2.2: Service Management</b></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>	<p>FA</p>	<p>In the absence of the facility manager, the nurse manager deputises, with support from the clinical team leader. When the nurse manager is absent, the clinical team leader takes responsibility for clinical oversight. The facility manager, the nurse manager and clinical team leader confirmed their responsibility and authority for these roles.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management plan 2015-2016 includes quality goals for 2016. There is an internal audit programme and completed internal audits for 2015 and 2016 were reviewed. An external auditor is responsible for managing the internal audit programme and audits non clinical areas. The nurse manager manages the clinical audits. The quality co-ordinator is responsible for collating and analysing quality data to identify trends and generates reports and graphs using an electronic programme. Data is reported monthly to the facility manager and nurse manager, as well as benchmarking data via an external agency. Clinical indicators and quality improvement data was evidenced on various registers and forms. Corrective actions are developed, implemented and evaluated. Meeting minutes and reports also evidenced discussion of any trends identified, as well as reporting on infection control and health and safety matters. Staff reported they are kept well informed of quality and risk management issues including clinical indicators. Copies of meeting minutes and graphs of clinical indicators were available for staff to view.</p> <p>Adverse events are documented on accident/incident forms and copies of these were retained in the residents' files.</p> <p>Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures as required. Care staff confirmed the policies and procedures provided appropriate guidance for the service delivery and they were advised of new policies / revised policies at meetings and handovers.</p> <p>There is a hazard register that identifies health and safety risks both potential and actual. Risks associated with human resources management, legislative compliance, contractual risks and clinical risk are documented. A health and safety manual includes relevant policies and procedures. The health and safety representative had a good understanding of their role.</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>Staff document adverse, unplanned or untoward events on an incident/accident form. The nurse manager and the quality coordinator review the forms and corrective action plans are developed. The incident/accident forms are then maintained in residents' files and entries made in residents' progress notes. Data is collated and separated into three levels – major, moderate or minor events. A monthly review is undertaken and results reported to the owner and staff.</p> <p>Families are kept well informed following any adverse event experienced by their relative. Families confirmed this. Staff are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct, which was confirmed through review of staff files and staff interviews. Policy and procedures comply with essential notification reporting including health and safety, human resources and infection control. The facility manager advised there have not been any essential notifications made since the previous audit.</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>FA</p>	<p>There are policies and procedures on human resources management. Job descriptions that outline accountability, responsibilities and authority, employment agreements, completed orientations, competency assessments and police vetting were on staff files.</p> <p>The inservice education programme is the responsibility of the nurse manager. Inservice education is provided at least monthly. Staff are encouraged to complete education modules via New Zealand Qualifications Authority Unit Standards. The nurse manager is an assessor for the programme. Individual records of education are maintained for each staff member as are competency assessments. There are attendance records for each education session. External speakers are used for some of the inservice sessions and staff also attend external education.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff performance is reviewed at the end of the orientation and annually thereafter. Orientation for staff covers the essential components of the service provided.</p> <p>Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.</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 that their performance appraisals are current.</p> <p>The nurse manager and clinical team leader have completed the interRAI education programme.</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>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 minimum number of staff is provided during the night shift and consists of one registered nurse and one caregiver. The facility manager and the nurse manager are on-call after hours. Care staff interviewed reported there are adequate staff available and that they were able to get through the work allocated to them. Residents and families confirmed there are enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.</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>All components of the residents' records reviewed included the resident's unique identifier. The clinical records reviewed were well-organised and integrated, including information such as medical notes, reports from other health professionals and laboratory results.</p> <p>Resident-related information is kept in both hard-copy and electronic files. These files were maintained securely. Electronic files, such as the interRAI system or electronic medication management system, were password protected and can only be accessed by designated staff. Hard copy information is kept in locked cupboards in the two nurses' stations, and these were observed to be kept locked when no staff were present. Archived material for current and past residents was also securely stored and easily retrievable.</p> <p>Registered nurses completed detailed progress notes for all hospital-level residents each shift, recording resident response to service provision and progress towards identified goals. Progress notes of rest-home level residents are updated by care givers every shift, and also included entries by registered nurses as required. The name and designation of the person making entries in to the clinical record was easily identifiable.</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>Entry to the service is guided by the resident screening and selection policy. Prospective residents are provided with a detailed information pack about the service; they and their family/whanau are encouraged to visit the facility prior to admission, and to complete a pre-screening form. The information pack sighted included a pamphlet about the service, admission agreement and Ministry of Health brochure about residential aged care requirements and processes. The CTL advised that residents can only be admitted when their level of required care has been assessed and confirmed by the Needs Assessment and Service Coordination Service (Supportlinks).</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them as part of that process.</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>The discharge, death, transfer policy provides guidance for staff in relation to resident transfer/exit from the service. The CTL advised that the service uses the DHB's 'pink envelope' system to facilitate transfer of residents to and from acute care services. This includes copies of the nursing assessment, medication chart, enduring power of attorney, and the service's own nursing referral form. Examples were sighted of detailed progress note records related to the information transferred with a resident.</p> <p>Examples of completed referral forms were sighted in the files of residents recently transferred to an acute facility.</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>FA</p>	<p>All aspects of medication management comply with legislative requirements and safe practice guidelines.</p> <p>The services uses an electronic medication management system. Twelve medication charts were reviewed, and all contained a current photograph of the resident and their allergy/sensitivity status. A report generated from the medication management system for the previous week confirmed that all medications had been administered as prescribed and/or the reason for non-administration had been recorded. All medication charts had been reviewed by the doctor within the previous three months. The service does not use medication standing orders. Processes are in place for residents to self-medicate, should this be required.</p> <p>Medications are supplied to the facility using the blister pack system. Evidence was sighted that these packs are checked against the medication chart by a RN on arrival to the service. Surplus and expired medication is returned to the pharmacy. All medications in the medication trolleys and stock cupboards were within current use date. A stocktake of all controlled medication is undertaken weekly. Records of the daily check of the medication fridge temperature were sighted.</p> <p>Registered nurses, all of whom have a current medication administration competency assessment, administer all medication in the facility. Medication training was held for registered nurses in February 2016. An observation of a medication round confirmed that medications were administered in a safe and appropriate manner.</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</p>	<p>PA Low</p>	<p>All aspects of food service delivery, with the exception of the menu approval within the past two years, comply with legislative and best practice requirements.</p> <p>An experienced, enthusiastic and qualified chef is responsible for managing food services within the facility. All cooks have completed NZQA Unit Standard 167 food safety. On inspection, the kitchen was well maintained, clean and tidy. Food storage complied with all current legislation. Food in the fridge and</p>

<p>component of service delivery.</p>		<p>freezers was dated and covered. Cleaning schedules were sighted, together with evidence of their implementation. Chemical checks were completed monthly, with equipment such as dishwashers being regularly serviced. Records were sighted that fridge and freezer temperatures were monitored daily and remained within recommended ranges.</p> <p>The kitchen catered for a range of nutritional requirements. Specialised crockery, such as lip plate and feeding cups, are available. There are two dining areas for residents, or they may have meals in their own room if they wish.</p> <p>Residents and family members spoke of their enjoyment of meals, and appreciated how meals were tailored to meet their individual preferences.</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>	<p>FA</p>	<p>The CTL advised that if a prospective resident did not meet the entry criteria, or there was currently no vacancy, then they would normally be redirected to Supportlinks to find appropriate care/placement. The CTL would also explain the reasons why admission had to be declined, and direct families to the Eldernet website so that they could identify other facilities that may have vacancies if that was appropriate.</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>PA Low</p>	<p>Residents are assessed by a registered nurse within 24 hours of admission. A short term care plan is developed utilising a range of information provided by the resident/family, the NASC assessment, clinical assessments such as falls risk and pressure area risk, and any other relevant referral information. Within three weeks of admission a long term care plan is developed, although these plans were not consistently informed by an interRAI assessment and interRAI reassessments were not consistently completed as part of the regular assessment/review process.</p> <p>All residents' records reviewed demonstrated evidence of resident/family involvement in the assessment process, and subsequent development of care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote</p>	<p>FA</p>	<p>All residents have an individualised care plan which provides guidance for care delivery staff to support the resident's identified needs. This was sighted in all of the resident records reviewed. Plans reflected the support needs of residents, their current interRAI assessment findings, clearly outline resident abilities, and strategies to promote their independence. Residents and families stated they felt included</p>

continuity of service delivery.		in the development of these plans, and their ongoing evaluation. Clinical files are integrated.
<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>	FA	<p>Registered nurses are on duty 24 hours a day who provide support and guidance for care delivery staff, with senior nursing staff always available on site or on call as required.</p> <p>With the exception of interRAI assessments, there was evidence in all resident records reviewed of regular, timely and comprehensive ongoing assessment of needs which then informed the provision of care services. (Refer also to criterion 1.3.4.2.) Detailed entries were sighted in the residents' progress notes especially when there were any changes to resident's needs.</p> <p>Both a doctor and another health professional expressed their satisfaction with care delivery standards.</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>	FA	<p>The activities programme is a strength of the service. Refer also to criterion 1.1.12.2.</p> <p>A qualified and very experienced diversional therapist (DT), leads the activities programme. The DT has completed ongoing training relevant to the role, as confirmed in training records, and is a member of the local DT group. The DT explained that residents' previous and current interests are assessed on admission and individual activity plans completed within three weeks. Resident participation in the activities programme is reviewed weekly, and their plan adjusted as necessary. This was confirmed in all resident files reviewed.</p> <p>Residents' activities assessments help inform the development of the monthly activity programme. Each resident receives an individual copy of the monthly programme. Activities planned for July included weekly exercise classes with a physiotherapist, reminiscence, community outings, entertainment, church services, movies, boccia and housie, crafts, art group, a men's visit to the Cosmopolitan club, and a mid-winter dinner. Activities are provided both in a group and one-on-one basis, together with support from volunteers, such as a local librarian.</p> <p>All residents and families interviewed commented on the variety of activities available, and their enjoyment of the programme. The most recent satisfaction survey identified a 97% satisfied/very satisfied rating in relation to the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	FA	<p>Care plans were evaluated at least six monthly and more frequently if clinically indicated, as sighted in all plans reviewed. Evaluations were undertaken by registered nurses and detailed the resident's progress towards achieving their identified goals. Clinical reassessments were also undertaken as part of the evaluation process, although interRAI reassessments were not consistently completed. Refer also to</p>

manner.		criterion 1.3.4.2. Short term care plans were reviewed in a timely manner. When progress was different from expected, care plans were updated accordingly.
<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 right of residents to access other health and/or disability providers is maintained. Residents are able to choose who will provide their medical services. Support is available to transport and accompany residents to external health-related visits, as sighted in resident records and confirmed during interviews with families.</p> <p>If the need for other services is identified, the CTL advised that the resident's doctor is advised, and referrals to specialist providers are usually made by the doctor. Copies of such referrals were sighted in a number of clinical files, including referrals to the dietician, tissue viability nurse, and specialist palliative care. The resident/family confirmed on interview that they are kept informed about the referral processes.</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>There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are throughout the facility and accessible for staff. The hazard register is current. Education to ensure safe and appropriate handling of waste and hazardous substances has been provided to staff.</p> <p>There was protective clothing and equipment in the sluice room and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff.</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>	FA	<p>A current building warrant of fitness was displayed. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio-medical equipment is current.</p> <p>There are external areas available that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use</p>

		and they are competent to use it.
<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>Eight bedrooms share a full ensuite between two rooms and one room has its own ensuite. There are adequate numbers of communal bathrooms and toilets throughout the facility. Residents reported that there are sufficient toilets and they are easy to access.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote residents' independence.</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>All bedrooms are single. There is adequate personal space provided for residents and staff to move around within the bedrooms safely. Residents spoke positively about their accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheel chairs.</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>	FA	<p>There are areas for residents to frequent for activities, dining, relaxing and for privacy. Residents, family and staff confirmed these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</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</p>	FA	<p>Apart from resident's personal clothes, all laundry is washed off site. Residents and family reported the laundry is managed well and resident's clothes are returned in a timely manner.</p> <p>There are dedicated cleaners on site who have received appropriate education. A cleaner and training records confirmed this. Chemicals are stored in a locked cupboard. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme</p>

is being provided.		and by personnel from the external company that supplies the chemicals.
<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>	FA	<p>There is an approved fire evacuation plan. There is an evacuation policy on emergency and security situations that covers all service groups at the facility. A fire drill takes place six-monthly with a copy provided to the New Zealand Fire Service. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>There is always at least one staff member on duty with a current first aid certificate.</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, cell phones and gas BBQs.</p> <p>There are call bells to alert staff. Residents and families reported staff respond promptly to call bells. Contractors must sign in and out of the facility. They are also made aware of any hazards on site. The external doors are locked in the evenings.</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. Heating is provided by electric heaters. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light.</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>An experienced registered nurse is the designated infection control coordinator (ICC). Infection control matters, including surveillance results, are reported monthly to the NM, the FM and owner. Infection control results are also reported every two-months to the Quality/Health and Safety Committee, and shared with staff via regular staff meetings and at staff handover meetings. This was confirmed in staff interviews.</p> <p>Infection control management is guided by a comprehensive infection control manual produced by an external provider. The manual includes definitions, procedures, guidelines to identify infections, information for all employees related to accidents, spills, needle stick injury prevention, sharps management and single-use items. The service has an Infection Control Programme 2015-2017, which outlines how infection control is managed and implemented across the service.</p>

		Signs at the two entrances to the facility ask anyone who is or has been unwell to not enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell.
Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICC has been in the role since February 2016. They have completed specific education related to the role, and are a member of the local infection control coordinators group. The ICC is also able to use a range of other resources to support their role, including utilising the expertise and experience of senior nursing staff at the facility, the MidCentral Health Infection Control Team and the public health unit. The coordinator advised that in their infection control capacity they have access to resident records and diagnostic results to ensure timely treatment and resolution of infections.  The Quality/Health and Safety committee includes the NM, CTL, as well as representatives from housekeeping, laundry, maintenance and the health and safety representative. Protective equipment is freely available to staff, who confirmed the availability of this equipment. Hand sanitisers are easily accessible around the facility. The service also maintains a supply of additional equipment in case of an infection outbreak.
Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	A comprehensive and current resource manual, produced by an external provider, guides infection prevention and control practices. These comply with relevant legislation and current accepted good practices. Housekeeping, laundry and kitchen staff were observed to be compliant with generalised infection control practices. Care delivery staff were observed using hand-sanitisers on a regular basis and wearing disposable aprons and gloves as appropriate.
Standard 3.4: Education  The organisation provides relevant education on infection	FA	The ICC advised that infection control is a component of the staff orientation programme. Infection prevention and control education is made available to staff three times each year, as confirmed in staff training records and the annual education plan.

<p>control to all service providers, support staff, and consumers.</p>		<p>This education is provided by suitably qualified registered nurses, including the ICC. The ICC also advised that additional staff education is also provided on an as-required basis, such as if there was an infection outbreak or if there were an increased incidence of resident infections, such as urinary tract infections.</p> <p>Education with residents is generally on a one-to-one basis. This may include reminders about handwashing or strategies to minimise the possibility of coughs and colds spreading to other residents.</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>	<p>FA</p>	<p>Surveillance of an appropriate range of infections is undertaken on a monthly basis. This includes data related to soft tissue/skin, urinary tract infections, respiratory, eye, gastrointestinal and other infections. All infections are recorded on an incident form, while the ICC also records these in an infection register (sighted).</p> <p>The ICC develops the monthly surveillance record. This information is entered into a long-standing database, which allows for easy identification of trends over a lengthy time period. Surveillance graphs are produced on a six-monthly basis and made available to staff, although the facility is now going to produce these graphs on a monthly basis to support more timely analysis of trends. Results are also benchmarked with an external benchmarking organisation.</p> <p>The monthly surveillance results are reported to the NM and FM, who then discusses this information with the facility owner, as well as to the Quality/Health and Safety Committee. Surveillance results are also regularly reported at staff meetings, and handover meetings as required. This was confirmed in meeting minutes.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service demonstrated that the use of restraint is actively minimised and two residents are currently being managed using low beds and landing mats. There were seven residents using restraint and two residents using an enabler during the audit. The restraint coordinator is a registered nurse and demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register is current and updated. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers.</p> <p>The restraint approval group forms part of the quality and staff meeting and is held three monthly. Meeting minutes confirmed this.</p>
<p>Standard 2.2.1: Restraint</p>	<p>FA</p>	<p>A signed job description for the restraint coordinator was evident in the restraint folder. Responsibilities of the restraint coordinator and approval group are clearly outlined. Restraints to be used for the residents</p>

<p>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>		<p>are approved by the restraint approval group prior to commencing the restraint, this includes the resident's GP. The GP completes three-monthly review of the restraints in use.</p> <p>Restraint use is discussed in the quality and staff meetings. Staff confirmed their knowledge of the restraint processes.</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	<p>Restraint assessment forms, completed prior to commencing any restraint, were in the files of those residents using restraint. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. Long term care plans clearly documented desired outcomes. Staff demonstrated good knowledge in maintaining culturally safe practice when completing assessments for restraint use.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Safe use of restraint is actively promoted. Restraint usage has decreased by two since the last audit. There is a current and updated restraint/enabler register. The risk management plans ensure the resident's safety while using restraint. Staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. There are restraint minimisation policies and procedures that are accessible for all staff to read. There were no restraint-related injuries reported. There were monitoring forms for all residents who are using restraint and these were completed as required.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Restraint and enabler use is evaluated three monthly. Consents and evaluation forms were signed by the GP and the residents' families. The evaluation form included the effectiveness of the restraint and the risk management plans documented in the long term care plans. Staff confirmed their feedback was obtained by the restraint coordinator when evaluating the restraint in use. The restraint approval group evaluated the restraints in use at least three monthly.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p>	FA	<p>The restraint approval group is responsible for monitoring and reviewing restraint. Restraint is also monitored through the internal audit programme. Identified issues are discussed in the quality and staff</p>

Services demonstrate the monitoring and quality review of their use of restraint.		meetings as well as additional education that is required to support staff. This has included education relating to restraint and challenging behaviour. Staff had good knowledge relating to managing challenging behaviour.
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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	<p>The service’s informed consent policy provides guidance on resuscitation and advance directives. In all ten resident files reviewed, a completed resuscitation/not for resuscitation order was in place. When residents were considered competent to make this decision, the doctor had completed the form with that resident. Medically-initiated do not resuscitate orders were also in place for residents who had not been able to participate in that decision.</p> <p>The service also has an advance directives order form, which includes information on future treatments, and transfer to acute care services. This form is to be signed by the resident and their doctor. In four instances, the form had been completed by the doctor, but there was no evidence of the resident having signed the form, or a record of their verbal consent to the order.</p>	Four advance directive order forms had not been signed by the resident concerned and/or there was no record of their verbal consent to the order.	<p>All advance directive forms in residents’ files are signed by the resident concerned, or there is documentation to record their verbal consent to the order.</p> <p>180 days</p>

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Low</p>	<p>A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs are easily accessible to kitchen staff. Residents are weighed monthly, results analysed and nutritional supplements administered as prescribed.</p> <p>The service operates a four weekly menu cycle, with summer and winter menus. The menu was last reviewed by a registered dietitian in December 2013.</p>	<p>The menu has not been reviewed by a registered dietitian within the past two years.</p>	<p>The menu is reviewed by a registered dietitian every two years.</p> <p>180 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Low</p>	<p>Initial assessments were completed in a timely manner by registered nurses. Hard copy assessments such as pain, continence, falls risk and pressure area risk were also undertaken as part of the development of the long-term care plan.</p> <p>The CTL advised that although all residents had a current interRAI assessment, these had not been completed within the required timeframes. Six residents' files were reviewed initially in relation to interRAI assessment, with the sample then extended by another four files. Although all files contained a current interRAI assessment, the required timeframes for assessment/reassessment had only been met for two residents. The service currently has two interRAI assessors on staff, with another trained assessor soon to start work. An email was sighted confirming that four staff members have been on the waiting list for assessor training since the end of 2015.</p>	<p>Although all residents had a current interRAI assessment at the time of the audit visit, these assessments/reassessments had not been completed within required timeframes.</p>	<p>InterRAI assessments are completed within required timeframes.</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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.	CI	The diversional therapist has designed several specific initiatives to support and promote residents' involvement with the local community. During a 2014 review of the activities programme it was identified that residents had limited opportunities to interact with their community, other than visiting entertainers, groups and their own visitors. An initiative was implemented to minimise travel and access difficulties for residents, but which would increase the opportunities for socialisation and interaction with others. Since late 2014 residents have been transported to a local coffee shop in the local mall, using both the facility van and mobility taxis, where they are joined by family members and volunteers. Here they can not only select their own lunch, interact with other residents and family/volunteers, but the location of the coffee shop means they have limitless opportunities for 'people watching'. Before they return home, residents also have the opportunity of doing some personal shopping, or being taken around the mall to window shop and chat. Seventeen residents have been regularly involved in this activity in the past twelve months, and its popularity is such that it is now a weekly event. Feedback was sighted from residents, family members and volunteers, together with the results of the past two resident satisfaction surveys, which strongly reflected how important this	It was identified that there were limited opportunities for residents to interact with the local community. Residents are now able to meet with family, friends and volunteers on a regular basis at a venue that not only provides them with the opportunity to share a meal together, but also actively engage with the wider community. The feedback related to this initiative was overwhelmingly positive, and it is a valued

		initiative had been to enabling residents to maintain their community links.	component of the activities programme.
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End of the report.