

Henderson Retirement Home Limited - Evergreen Retirement Home

Introduction

This report records the results of a Provisional 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 HealthShare 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:	Henderson Retirement Home Limited
Premises audited:	Evergreen Retirement Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 August 2016 End date: 5 August 2016
Proposed changes to current services (if any):	Potential sale of service
Total beds occupied across all premises included in the audit on the first day of the audit:	8



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.

General overview of the audit

Evergreen Retirement Home provides rest home level care for up to 17 residents. This provisional audit was conducted against the relevant Health and Disability Standard and the contract with the District Health Board. The audit process included an interview with the prospective provider and the current owner, a review of policies and procedures, the review of resident and staff files, observations, and interviews with residents, family, a general practitioner, management and staff.

There were eight beds occupied on the day of the audit. The prospective owner states that there will be no change to any aspect of the business in the near future. The current owner states that they will support the potential owner to transition into the service. A change in ownership is planned to occur at the end of August 2016.

Improvements are required to the following: advance directives; documentation of the complaints register; business, transitional and quality plans; the quality management programme; incident reporting; staff records; staff training; identifying details of the resident in resident records; service agreements; engagement of residents and/or family in the assessment and care planning

process; the process of assessing the resident; medication administration; the menu; the laundry, the laundry; storage of chemicals; checking of fire equipment; staff on duty with first aid certificates and documentation of environmental restraint.

Consumer rights

Staff are able to demonstrate an understanding of residents' rights. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained. The service informs residents and family of the complaints process.

Organisational management

The organisation's mission statement and vision is documented. There is a current business plan. Quality and risk management systems are documented and intended to support service delivery. Human resource policies include some recruitment information, selection, orientation, staff training and development. Staffing levels meet occupancy and acuity levels and residents state that they have adequate access to staff when needed. Resident records are maintained in a secure manner.

The potential owner is prepared to take over the service at the end of August 2016 depending on the outcome of the audit. The current owners are committed to providing a handover to the potential owners with support as required. The potential owner does not wish to change any aspect of the service at this point.

Continuum of service delivery

Each stage of service provision is expected to be developed with resident and/or family input and coordinated to promote continuity of service delivery. Each resident has a current interRAI assessment and there is a care plan that reflects the individual cares required.

The residents and family interviewed confirm a high level of satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis with comprehensive records maintained.

A secure medicine management system is in place. Staff are observed to administer medicines as per policy.

Food, fluid, and nutritional needs of residents are documented. Any additional dietary requirements are met. There is a central kitchen and on site staff provide the food service. The kitchen staff have completed food safety training.

Safe and appropriate environment

All building and plant comply with legislation with a current building warrant of fitness in place. A maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

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

Restraint minimisation and safe practice

Restraint policies and procedures include definitions of restraint and enablers which are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to

assist them to maintain independence and/or safety. There were no residents requiring enablers on audit days. There is practice that constitutes environmental restraint by the way of an outside gate having a key pad lock.

Infection prevention and control

Infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. Infection control is an agenda item at facility meetings. There is a documented surveillance programme with a low number of infections documented in the past year. Trends are reviewed. Staff have training around infection control.

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	30	0	6	9	0	0
Criteria	0	70	0	10	13	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility. New residents and families are provided with copies of the Code as part of the admission process.</p> <p>Staff have had training around rights and the Code in the past (refer 1.2.7.5). All staff were observed to implement rights as per the Code in their day-to-day practice.</p> <p>The potential owner states that they are not yet familiar with the Code however, the current owner states that they will provide training to the potential owner around the application of the Code to practice.</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>The service information pack includes information regarding informed consent. The registered nurse/manager, or the registered nurse, discuss informed consent processes with residents and their families during the admission process. Staff confirmed their understanding of informed consent processes.</p>

		<p>The informed consent policy and procedure directs staff in relation to gaining informed consent. This included guidelines for consent for resuscitation/advance directives. Staff ensure that all residents are aware of treatment and interventions planned for them, and that the resident and/or significant others are included in the planning of that care.</p> <p>All resident files identify that the required consents are collected.</p> <p>Advance directives are signed by the resident in some instances and by family for some.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Information on advocacy services is available at the entrance to the service.</p> <p>Staff training on the role of advocacy services is included in training on the Code with this has been provided to staff in past years (refer 1.2.7.5). Staff are able to describe how they can support the resident to access advocacy services if required.</p> <p>Discussions with family and residents identify that the service provides opportunities for the family/EPOA to be involved in decisions. Resident files include information on resident's family/whānau and chosen social networks.</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>	<p>FA</p>	<p>There are no set visiting hours and family are encouraged to visit at any time. Family report that there are no restrictions to visiting. Residents confirm that they are supported and encouraged to access community services with visitors or as part of the planned activities programme. One resident for example, attends a day programme three days a week that they describe as supporting their requirements for social engagement. Some residents walk to the shops and mall and others access the community with the support of staff.</p> <p>The facility is close to community facilities and residents are encouraged</p>

		to access these independently as able (refer 1.3.7).
<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>PA Moderate</p>	<p>Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Complaints management is explained as part of the admission process and is part of the staff orientation programme and ongoing education (refer 1.2.7.5). Residents and family confirm that they know that there is a form that they can document concerns of complaints on and state that they would approach management.</p> <p>The complaints register records the complaint, dates and actions taken. There were no outstanding complaints at the time of the audit. There are complaints raised through family meetings with the registered nurse/manager however these are not documented on the complaints register and there is little evidence that these are followed up.</p> <p>There have been two complaints raised by external authorities since the last audit. One has been closed out with no further actions and the other has some actions that require a further response. Both are documented on the complaints register.</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 registered nurse/ manager or registered nurse discusses the Code, including the complaints process with residents and their family on admission.</p> <p>Information regarding the Health and Disability Advocacy Service is clearly displayed in the foyer of the facility. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.</p> <p>Residents and family confirm that their rights are being upheld by the service. They are able to describe their rights and advocacy services particularly in relation to respect for them as people who live in the facility. All residents interviewed state that they are respected by staff and that staff provide support for them when required.</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 service has a philosophy that promotes dignity and respect and quality of life. Residents' support needs are assessed using a holistic approach. The assessment process includes gaining details of people's beliefs and values. Residents interviewed confirm that they are included in the care planning process and are addressed by their preferred name. Caregivers state that they support the residents' independence by encouraging them to be as active as possible</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner. This includes strategies to manage any behaviours of concern.</p> <p>The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility that can be used for private meetings. Caregivers reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents confirm that their privacy is respected.</p> <p>There is a process documented for identifying and reporting of any abuse or neglect. Staff interviewed are able to describe the policy. Staff and the general practitioner interviewed state that there is no evidence of any abuse or neglect. Residents stated that staff were respectful and were positive about care and support received.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service implements the Maori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan. Links to local Maori are available through the gerontology nurse specialist at the district health board.</p> <p>Any Maori resident living at the facility has their cultural needs assessed as part of the care planning process (refer 1.3). The identification of specific cultural needs is documented in the resident file if there are any specific needs or requests. Residents confirm that their cultural needs are met. Staff are aware of the importance of family in the delivery of</p>

		<p>care for the Maori resident.</p> <p>Staff interviewed can describe meeting cultural needs of residents and Maori staff interviewed confirmed their knowledge of support for Maori residents.</p> <p>The potential owner states that they will work with staff and the registered nurse/manager to guide service delivery for Maori.</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>	FA	<p>The service identifies each resident's personal needs from the time of admission. This is completed with the resident, family and/or their representative having input into the admission, assessment and planning processes.</p> <p>Residents determine when cares occur, choices in meals and choices in activities. Residents were observed to be given choice on the days of audit such as being able to get up in the morning when they want to, when they eat meals and when they wish to go out into the community. Caregivers are able to give examples of how choices are given to residents who have non-verbal or limited ways of communicating and this was observed on the day of audit particularly for one resident who had different ways of communicating.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff files have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. Residents expressed no concerns with breaches in professional boundaries, discrimination or harassment. Staff orientation and their employee agreement includes standards of conduct. Interviews with staff confirm their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There are policies and procedures to guide practice. These have been developed by an external consultant and align with the health and disability services standards. Policies are reviewed annually to three yearly depending on the policy and changes in legislation, evidence and</p>

		<p>best practice</p> <p>A staff training programme is implemented (refer 1.2.7.5) and staff can describe sound practice based on policies and procedures, care plans and information given to them via the registered nurse.</p> <p>Consultation is also available with health professionals and specialists in the region with staff able to describe how and when they can make contact. Residents interviewed stated that they are satisfied with the care delivered. They state that they are in a safe place.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure was available. Family members interviewed confirm that they are informed if the resident has an incident, accident, or has a change in health or needs (refer 1.2.4). Family contact is recorded in residents' files.</p> <p>Interpreting services are available from the district health board. There were no residents requiring interpreting services at the time of the audit although some residents have different ways of communicating. Staff were observed to communicate with residents in a way that they could understand.</p> <p>The information pack is available in large print and this could be read to residents. Residents are required to sign an admission agreement on entry to the service (refer 1.3.1). This provides clear information around what is paid for by the service and by the resident.</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>	PA Moderate	<p>The service provides rest home level of care under the aged care contract. The service is able to provide support for a maximum of seventeen residents with eight beds occupied on the days of the audit.</p> <p>There is a clear mission, values and goals documented in the business plan. These are communicated to residents, staff and family through information in the welcome pack and in staff training. The potential</p>

		<p>owner states that they will follow the current business plan.</p> <p>Evergreen Care is led by the registered nurse/ manager. The registered nurse/manager has resigned from the service and the owner has provided emails that confirm that they have approached two recruitment agencies to put staff in place. There is also documentation confirming that the registered nurse/manager has agreed to stay in the service as a registered nurse in the interim.</p> <p>The potential owner and the current owner confirm that there will be a handover period with the current owner providing support as required. A transition plan is not yet documented. One potential owner states that they have 13 years management experience and qualifications in the information technology area and the second is stated to have qualifications in accountancy. There is a plan for one of the potential owners to be based in the service to support staff and residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>A registered nurse/manager provides operational management in the service. The registered nurse provides the second in charge role but is leaving the service on the last day of the audit. The current registered nurse/manager has agreed to take on the role of registered nurse in the interim and the current owner states that bureau nurses will provide cover if required. This was also confirmed as the plan in the interim until appointments are made by the potential owner.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>Evergreen Care uses the quality and risk management framework to guide practice. This has been developed by an external contractor with policies updated yearly to three yearly depending on the policy and as changes occur. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. There is an updated pressure injury policy that aligns with the skin management and wound management policies.</p> <p>There is a document control process that ensures that correct versions of policies and procedures are used by managers and staff.</p>

		<p>There is a business plan (refer 1.2.1) and a draft quality and risk management plan in place. The registered nurse/ manager states that the quality and monitoring registered nurse from the district health board is supporting the development of the quality plan.</p> <p>Service delivery is being monitored through a monthly report documented by the registered nurse, complaints (refer 1.1.13), review of incidents and accidents and partial implementation of an internal audit programme. Some corrective action plans are documented.</p> <p>Meeting minutes provide evidence of communication with staff regarding aspects of quality improvement and risk management. There are some individual resident and individual family meetings that keep residents and family informed of any changes. Resident meetings are no longer held as a group. Staff report that they are kept informed of quality improvements.</p> <p>A risk management programme is in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated.</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>PA Low</p>	<p>Policies require all incidents, accident and adverse events to be reported immediately. Responsibilities are clearly identified. Incident forms are completed by staff when events occur. Families state that they are notified of any adverse, unplanned or untoward events with confirmation of this documented in the progress notes. Not all incident forms record evidence that family have been informed.</p> <p>The registered nurse/ manager understands the obligations in relation to essential notification reporting and knew which regulatory bodies must be notified. Staff state that they report and record all incidents and accidents and that this information is shared at all levels of the organisation.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>PA</p>	<p>Policies and procedures identify human resources management that</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>Moderate</p>	<p>reflect good employment practice and meet the requirements of legislation. Newly appointed staff are police vetted upon employment. Professional qualifications are validated as part of the employment process and checked annually. Job descriptions describe staff responsibilities and best practice standards</p> <p>Staff state that they complete an orientation programme. Staff are provided with training and education related to their appointed roles with an annual training plan documented. Education records are retained in staff files and in training records. Documentation of training provided to staff indicates that they have received some training such as palliative care in the past year.</p> <p>Annual performance appraisals are not conducted.</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>A policy identifies staffing levels and skill mix. Documentation identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe and quality care. The registered nurse/manager reports that additional staff would be rostered to meet residents' needs if required. Rosters reviewed confirm that staff are replaced when on annual leave or sick leave.</p> <p>Staff confirm there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. There are also kitchen, cleaning, activity and maintenance staff to support residents. Residents interviewed state that all their needs are met in a timely manner.</p> <p>The registered nurse/manager is supported by a second registered nurse. The registered nurse/manager or the registered nurse is on call after hours.</p> <p>The potential owner does not have plans to change staffing.</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>PA Low</p>	<p>Information is entered into the resident information management system in an accurate and timely manner. Information of a private or personal nature is maintained in a secure manner and is not publicly accessible.</p>

		<p>Archived records are stored onsite.</p> <p>Progress note entries are made by staff on duty on each shift. Records are legible and the name and designation of the staff member documented.</p> <p>Each resident has a file that includes assessment, planning and other information related to their care.</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>PA Moderate</p>	<p>Entry and assessment processes are recorded. Information is communicated to residents, family, relevant agencies and staff. The admission agreement defines the scope of the service and includes all contractual requirements. On the day of the audit, residents and family confirmed the admission process was completed in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.</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>There is appropriate communication between families and other providers, that demonstrates transition, exit, discharge or transfer plans are communicated, when required. The residents' files evidence appropriate records relating to transfers where this is required.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The medication area, including controlled drug storage, evidences a secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Medication is checked on arrival to the service. The fridge used to store medications is maintained at a correct temperature for the medications stored. Temperatures are checked weekly. There is a process implemented to return expired medication to the pharmacy.</p> <p>Controlled drugs are stored in a locked cabinet in the locked medication room. A check of balances of controlled drugs in the register matched controlled drugs in the cabinet. There are weekly stock takes. Documentation of controlled drugs is completed by two staff in the register and mostly by two staff in the medication administration sheet.</p>

		<p>Staff authorised to administer medicines do not all have current competencies. Staff specimen signatures are recorded.</p> <p>Residents do not self-administer medications. The general practitioner reviews each resident at least three monthly.</p> <p>Medication identified as required (PRN) includes the maximum dose and indications for use are documented. Some documentation includes transcribing of information on the administration signing sheet. At times, staff do not document administration of lotions.</p> <p>The potential owner has no plans to change the medication systems.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>The food service policies and procedures are appropriate to the service setting. The cook describes using the menus with variations to the menu on a daily to weekly basis.</p> <p>In interview, the cook confirmed they were aware of the residents' individual dietary needs. The residents' dietary requirements are identified, documented and communicated to the cook verbally however the individual resident dietary profiles are not current. The copies of the residents' dietary profiles are located in the kitchen.</p> <p>Residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids was provided. Kitchen staff have not completed food safety training in the past two years (refer 1.2.7).</p> <p>Temperatures are recorded of the fridge and the freezer. Food temperatures are recorded. All temperatures are within normal range. Residents state that food is well presented and residents are satisfied with the meals provided.</p> <p>The food safety courses completed by the cooks as displayed in the kitchen.</p> <p>The potential owner has no plans to change the food service.</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>There is a process to inform residents and family, in an appropriate manner, of the reasons why the service has been declined. The residents would be declined entry if not within the scope of the service or if a bed was not available.</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 Moderate</p>	<p>The facility has processes in place to seek information from a range of sources, for example; family; GP; specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.</p> <p>There was evidence of residents' discharge/transfer information from the district health board (DHB), where required. The facility has appropriate resources and equipment, confirmed at staff interviews. Assessments are conducted in a safe and appropriate setting including visits from the doctor. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</p> <p>Improvements are required to the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Residents' care plans are individualised. Care plan interventions reflect the level of care required. In interviews, staff reported they receive adequate information for continuity of residents' care. The residents state that they do not have input into their care planning and review (refer 1.3.3.4). There is evidence of specialist involvement where this is required.</p> <p>A pressure injury (grade two) was documented but healed within two weeks. The general practitioner monitored progress and staff documented an assessment, plan and monitoring form. A pain assessment was also completed. Communication with the resident was documented.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to</p>	<p>FA</p>	<p>Residents' care plans evidence interventions, desired outcomes or goals of the residents (refer to 1.3.4).</p>

<p>meet their assessed needs and desired outcomes.</p>		<p>In interview, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files.</p> <p>Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they were familiar with the current interventions of the resident they were allocated. Short term care plans are completed for short term problems. Short term care plans were developed, when required and signed off by the registered nurse when the issue is resolved.</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 diversional therapist is engaged to provide activities to the residents for six hours a day, five days a week. In interview, the diversional therapist (DT) confirmed the service has appropriate equipment. The DT has experience as a registered nurse in another country and plans and implements the activities programme. Caregivers are to implement residents' activities according to the activities programme when the DT was not present.</p> <p>Regular exercises are provided. The activities programme includes input from external agencies and supported ordinary unplanned/spontaneous activities including festive occasions and celebrations. Residents' verbally feedback on the programme.</p> <p>Observation of the diversional therapist and the activities programme on the days of audit indicated that residents enjoy the programme, are provided with a range of activities including one to one activities and outings and their individual needs are met. The diversional therapist documents an assessment and plan for each resident and comprehensive progress notes on a daily basis. An attendance register is maintained.</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>Time frames in relation to care planning evaluations are documented.</p> <p>The residents' progress records are entered in daily. When resident's progress is different from expected, the RN contacts the GP, as required. Family were notified of any changes in resident's condition, as</p>

		<p>confirmed at family interviews.</p> <p>There was recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this was required.</p>
<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>Appropriate processes are in place to provide choices for residents in accessing or referring to other health and/or disability services. Family communication is documented in the progress notes and confirms family involvement.</p> <p>Evidence in two resident files noted that residents are referred to the hospital in a timely manner when issues arise.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. The hazard register is current. Staff have not received training and education to ensure safe and appropriate handling of waste and hazardous substances in the past two years (refer 1.2.7).</p> <p>Chemicals are not always stored securely (refer 1.4.6). The required personal protective equipment/clothing (PPE) is available. Staff confirm they can access PPE at any time and were observed wearing disposal gloves and aprons appropriately.</p> <p>The caregiver completing cleaning tasks demonstrated knowledge of handling waste and chemicals.</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>Documentation identifies that all processes are undertaken as required to maintain the current building warrant of fitness (expiry date in September 2016). Maintenance is undertaken by staff or contractors as required. Electrical safety testing occurs annually. Clinical equipment is</p>

		<p>tested and calibrated by an approved provider at least annually.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered.</p> <p>There are external areas with shade. There is a low gate with a pin code access for security (refer 2.1). Residents and family members confirm that the environment is suitable to meet their needs.</p> <p>The potential owner/s have no intention of changing the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible toilets/bathing facilities. There is a visitor's/staff toilet and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Residents and family members interviewed report that there are sufficient toilets and showers.</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 of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Residents spoke positively about their rooms. Rooms can be personalized with furnishings, photos and other personal adornments and the service encourages residents to make the room their own.</p> <p>There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.</p>
<p>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</p>	FA	<p>The service has a lounge/dining area that is also used for activities. Residents can choose to have their meals in their room. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner that enables residents to mobilise freely.</p>

needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>PA Moderate</p>	<p>The service has procedures in place for cleaning with staff able to describe how they complete cleaning tasks. There is a dedicated storage area for cleaning equipment and chemicals however chemicals were sighted in different areas in the service in areas that were not locked. Cleaning is monitored by the registered nurse/manager. The facility was clean on the days of audit.</p> <p>All laundry, including residents' personal laundry is completed on site.</p> <p>Staff interviewed confirm they always have enough linen to meet day-to-day needs and there was plenty of linen in the cupboards on the days of audit.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>Emergency management policies and procedures guide staff actions in the event of an emergency. Emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. The registered nurse/manager states that fire equipment is checked annually by an approved provider however documentation to confirm this was not sighted.</p> <p>An approved fire evacuation scheme is sighted.</p> <p>Emergency supplies and equipment include food and water. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking.</p> <p>The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved fire evacuation plan. All resident areas have smoke alarms and a sprinkler system. Emergency education and training for staff includes six monthly trial evacuations.</p> <p>Not all staff have a current first aid qualification.</p> <p>Appropriate security systems are in place with staff checking that the premises are secure at night. Staff and residents confirm they feel safe at all times. Call bells are located in all resident areas. Resident and family interviews confirm call bells are answered within an acceptable</p>

		timeframe. Call bells randomly checked on the day of the audit are displayed and answered in a timely manner.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.</p> <p>Family and residents stated that the building is maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Infection control policies and procedures provide information and resources to inform staff on infection prevention and control. The delegation of infection control matters is documented in policies and procedures. The infection control coordinator is the registered nurse with the registered nurse/manager also providing support for the role.</p> <p>There is evidence that the staff meetings include discussion / agenda relating to infection control. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has access to relevant and current information which is appropriate to the size and complexity of the service, including infection control manual; internet; access to experts and education. Infection control is an agenda item at the staff meetings as sighted in minutes reviewed and in discussion with staff.</p> <p>The interview with the registered nurse/infection control coordinator confirms awareness of their responsibilities of the position.</p> <p>The visual inspection evidences that there are paper towels and flowing soap provided in all relevant areas on the days of audit.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interviews. The infection control policies and procedures are developed and reviewed regularly by an external consultant with input from the registered nurse/manager. Infection control policies and procedures identify links to other documentation in the facility.</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>	<p>FA</p>	<p>Infection control education is provided to all staff, as part of their orientation and as part of the on-going in-service education programme. In interviews, staff state that clinical staff identify situations where education is required for a resident such as hand hygiene; cough etiquette and one on one education is conducted. Education sessions have evidence of staff attendance/ participation and content of the presentations.</p> <p>The last training for staff around infection control has been provided in July 2016.</p> <p>The infection control coordinator has attended training at the district health board in 2014 and has attended training in 2016 in the service.</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>The infection control coordinator is responsible for the surveillance programme. Monthly surveillance data relating to number and type of infections is recorded with the following documented: individual records of each infection per resident; collation of data per site monthly; graphs of the data monthly, quarterly and annually and evidence that data is analysed and evaluated monthly including actions taken to address any issues or trends that are noted.</p> <p>Staff meetings are held monthly and meeting minutes show discussion of the data. Staff report they are made aware of any infections of individual residents by way of feedback from the registered nurse or registered nurse/manager through verbal handovers and progress notes.</p>

		<p>The infection control coordinator confirms that there have not been any outbreaks at the facility since their appointment to this position in 2015. Surveillance data was sighted and includes infection details related to files sampled.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded in policy. The restraint coordinator is the registered nurse.</p> <p>A low gate is locked with a pin code. Staff state that the gate is locked to prevent unwanted people accessing the service from the community and so that some residents do not wander onto a main road. Some residents remember the code to get out of the gate and there is a bell on the outside to ring for staff attention if they forget on the way back in. Some residents cannot remember the code but staff state that they can ask for the gate to be unlocked. Some residents are identified as not being able to go out by themselves as they may get confused however staff state that these residents do not wish to go out.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews. There were no residents at the facility using enablers.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	PA Low	There is a policy around advance directives with forms to complete. The general practitioner is required to identify competency of the resident to document an advance directive and the form is signed by the resident deemed competent in four of the six files reviewed.	Two advance directives have been signed by family members.	<p>Ensure that advance directives are documented as per the policy.</p> <p>180 days</p>
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Moderate	There is a complaints policy and process. The register states that there have not been any complaints from residents or family in the service. The two complaints referred by an external authority are documented on the register.	Complaints raised through family meetings are not documented on the complaints register and there is no evidence that these have been resolved.	<p>Document all complaints on the complaints register with evidence of implementation of the complaints policy and resolution of issues.</p> <p>90 days</p>

<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	<p>PA Moderate</p>	<p>The business plan is documented by the owner. The 2015 and 2016 business plans were sighted. The 2016 business plan does not reflect key issues for the business.</p> <p>The potential owner and the current owner can describe the process of transitioning the business from one to the other with the current owner providing support in the interim.</p>	<p>There is no evidence of review of the business plan or that the business plan reflects current direction and goals.</p> <p>A transition plan is not yet documented.</p>	<p>Ensure that the business plan reflects the goals of the service and that this is reviewed at regular intervals.</p> <p>A transition plan is not yet documented. (Required prior to purchase).</p> <p>Prior to occupancy days</p>
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	<p>PA Moderate</p>	<p>There is a quality framework documented and a draft quality plan.</p>	<p>A quality plan has not been ratified and implemented to date.</p>	<p>Document, implement and review a quality plan.</p> <p>60 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Moderate</p>	<p>There is evidence of some internal audits being completed against the internal audit schedule for 2016 however not all the required internal audits for 2015 and 2016 have been conducted. Any internal audits completed are tabled at the staff meeting with evidence that information is fed back. An audit of wounds including pressure injuries is not completed in the past year.</p> <p>There are records of meetings with individual family members as they are available.</p> <p>A satisfaction survey has not been circulated for a number of years.</p>	<p>The internal audit schedule has not been fully implemented and the schedule is not dated.</p> <p>Quality data does not include the identification of trends or areas for improvement.</p> <p>Resident meetings have not been held since September 2015 and satisfaction surveys have not been circulated.</p>	<p>Implement the internal audit schedule for the current year.</p> <p>Use quality data to analyse trends.</p> <p>Ensure that there are mechanisms implemented that allow discussion of issues and quality data where appropriate with residents and family.</p> <p>90 days</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>There is a process to document corrective action plans with some completed when issues have been identified. Not all issues identified through the internal audit programme, through meetings and through other ways of collecting data have been included in corrective action plans. There is little evidence of evidence of resolution of issues</p>	<p>Corrective action plans are not always documented and there is little evidence of documentation of resolution of issues.</p>	<p>Fully implement the corrective action planning process with resolution of issues documented.</p> <p>90 days</p>
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	<p>PA Low</p>	<p>Family state that they are informed of an incident. There is an incident form available to document that family have been informed. Five of the ten incident forms reviewed documented in 2015 and 2016 include evidence that family have been informed.</p>	<p>Not all incident forms record evidence that family have been informed.</p>	<p>Ensure that family are informed when an incident has occurred.</p> <p>180 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>Incident forms are documented by staff when events occur. Staff interviewed understand the reason for documenting incident forms and the reporting process. The process of reviewing incident forms was implemented. When there is an unwitnessed fall, there is an indication that observations have been completed immediately after the incident however the observations are not continued for a length of time to establish any potential change in status. One incident resulted in an injury that potentially indicated that observations should have been documented.</p> <p>One resident had a significant incident</p>	<p>Observations of vital signs are inconsistently documented for an unwitnessed fall or when there maybe potential injuries.</p>	<p>Ensure that the process for review of the resident following an unwitnessed fall or if there is a potential change in status of the resident is implemented.</p> <p>30 days</p>

		<p>and emergency services were contracted immediately. The incident form was well documented.</p> <p>The general practitioner states that staff inform them at the earliest opportunity if required following any incident.</p>		
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Moderate</p>	<p>The registered nurse/manager states that referee checks have been completed and the application form for each staff member reviewed includes details of referees who could be contacted. Documentation is not fully completed in staff files reviewed.</p>	<p>Staff records are incomplete with four of five files not including evidence of referee checks or criminal vetting. The file for the registered nurse/manager was not able to be sighted.</p>	<p>Ensure that staff recruitment information is kept on file and that all staff have a complete file.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>Two of the five staff files reviewed include a signed orientation checklist. Staff state that they have received an orientation.</p>	<p>Three of five staff files do not evidence completion of orientation.</p>	<p>Ensure that an orientation is provided to each new staff member.</p> <p>180 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>A training record is documented however this does not reference all aspects of training around the Health and Disability Sector Standards. Staff interviewed are able to describe care and support as per policy.</p> <p>Staff have completed interRAI training in the past but have since left the service.</p> <p>Staff have had a performance appraisal in the past however these are not completed annually.</p>	<p>Staff have not had training around key aspects of care and support such as abuse and neglect, the Code, aspects of clinical care.</p> <p>Neither of the staff have completed interRAI training.</p> <p>Staff do not have an annual performance appraisal.</p>	<p>Ensure that staff have access to training relevant to their roles.</p> <p>Provide staff with access to training around interRAI.</p> <p>Ensure that all staff have an annual performance appraisal.</p>

				90 days
<p>Criterion 1.2.9.10</p> <p>All records pertaining to individual consumer service delivery are integrated.</p>	PA Low	<p>Most resident information is kept in an individual resident file. Not all resident information includes the residents' details such as NHI number, the full name and date of birth. The activities records for each resident are kept separately by the activities coordinator. Incident forms are kept in a folder separate to the resident files.</p>	<p>Not all pages in the resident file include the name and identifying details of the resident.</p>	<p>Ensure that each page in the resident file includes the residents' name and details.</p> <p>180 days</p>
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Moderate	<p>NASC assessments are conducted prior to admission to the facility. Admission agreements are completed on admission. NASC assessments were sighted on files reviewed. Admission agreements were sighted in all resident records reviewed. One resident had had a re-assessment for a potentially different level of care in April 2016 however the needs assessor had not sent the report to date. An email from the needs assessor in August 2016 states that the report was in the mail.</p> <p>Admission agreements are required to be signed on the day of entry to the service.</p>	<p>One needs assessment for a resident potentially requiring a different level of care had not been received by the service.</p> <p>Not all admission agreements are signed on the day of entry or prior to entry to the service.</p>	<p>Access the outstanding needs assessment as soon as possible and ensure that any needs assessment reports are sent to the service in a timely manner.</p> <p>Ensure that admission agreements are signed on the day of entry to the service.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation,</p>	PA Low	<p>Residents' medicine charts evidence that all residents medication charts have photo identification; allergies are consistently recorded; all resident have a medication chart; discontinued medicines are dated and signed by the general practitioner.</p> <p>All resident medication files show</p>	<p>There is transcribing of as required medications on the administration sheet.</p> <p>At times, the use of prescribed lotions is not documented when administered.</p>	<p>Cease transcribing of instructions for administration of medication.</p> <p>Document when lotions are administered.</p>

protocols, and guidelines.		<p>evidence that the general practitioner has reviewed medication as required. As required medication records indication of use.</p> <p>The medication fridge temperatures are checked weekly with these within range for the medications in the fridge at the time of audit.</p> <p>The medication round was observed and evidenced that the registered nurse followed the policy when administering medications.</p>		60 days
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	<p>There is a process to complete annual medication competencies. The registered nurse observed to give medications was administering and documenting a record of the administration as per policy. The caregiver interviewed is able to describe the process for administration of medications as per the policy. Residents interviewed state that they receive medicines in a timely manner.</p>	<p>Not all staff have completed an annual medication competency.</p>	<p>Ensure that all staff who administer medications complete an annual medication competency.</p> <p>90 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Low	<p>Two staff sign the controlled drug register and one staff signs the administration sheet. There is only one resident using required controlled drugs and this has only been introduced since July 2016.</p>	<p>Two staff so not always sign for the administration of controlled drugs.</p>	<p>Ensure that there are two staff who sign for the controlled drug administration.</p> <p>30 days</p>
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or</p>	PA Moderate	<p>The last dietician review was completed in 2013. There is a three weekly menu.</p>	<p>The dietician has not reviewed the menu since</p>	<p>Review the menu in a timely manner.</p>

modified nutritional requirements or special diets have these needs met.			2013. The main cook does not follow the menu and at times the diary indicates that the menu is repeated over two days.	Ensure that the cook follows the menu. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	The registered nurse/manager and registered nurse describe a process that includes the residents and family in the assessment or care planning process.	Residents and family state that they are not engaged in the assessment or care planning process.	Engage residents and/or family in the assessment and care planning process. 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	Initial assessments are consistently completed within 24 hours of the resident entering the service. The registered nurse/manager has not completed interRAI training and the RN has not completed interRAI training (refer 1.2.7). All residents have a current interRAI assessment with a previous registered nurse contracted to complete these. The assessment prior to the current assessment has not been completed. The general practitioner is required to assess the resident on admission and this is documented as being completed within 48 hours for two of the residents reviewed.	InterRAI assessments have not been completed six monthly. InterRAI assessments completed are current but generic and often state 'refer to the care plan'. The general practitioner has not assessed the resident within 48 hours after admission for three of the residents reviewed (noting that this includes one resident admitted in 2016)	Provide evidence that assessments are completed six monthly. Ensure that interRAI assessments are completed by staff who are familiar with the current status of each resident. Ensure that the general practitioner assesses the resident within 48 hours of admission. 90 days
Criterion 1.4.6.2	PA	All laundry is completed on site. Staff	The laundry does not have	Ensure that the laundry

<p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>Moderate</p>	<p>interviewed, who complete the laundry, are able to describe how they separate clean and dirty laundry so that it does not get mixed up.</p> <p>On the days of audit it was difficult to tell which was clean and which was dirty laundry.</p>	<p>an adequately defined clean/dirty area.</p>	<p>has a clean and dirty area defined.</p> <p>90 days</p>
<p>Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	<p>PA Moderate</p>	<p>Chemicals are kept in a number of cupboards that are not locked. One resident is potentially requiring a higher level of care and maybe able to access chemicals.</p>	<p>Chemicals are not locked away.</p>	<p>Ensure that chemicals are kept in a safe and secure place when not in use by staff.</p> <p>30 days</p>
<p>Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA Moderate</p>	<p>Fire drills are completed six monthly with records of staff attendance maintained. The registered nurse/manager states that the fire equipment has been checked annually.</p>	<p>There is no documentation to confirm that fire equipment is checked annually.</p> <p>Not all staff have a current first aid certificate and the rosters do not indicate that there is always someone on duty with a first aid certificate.</p>	<p>Document evidence that fire equipment has been checked annually</p> <p>Ensure that there is always a staff member on duty with a current first aid certificate.</p> <p>30 days</p>
<p>Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer</p>	<p>PA Low</p>	<p>The facility is built on a corner of two busy roads. The facility's external areas are fenced off from the busy roads and there is a code lock on the garden gate. Residents who have the capability to operate the gate are able to enter and exit the grounds. There is no evidence of</p>	<p>There is environmental restraint, by the way of an outside garden gate having a key pad lock.</p>	<p>Document the use of environmental restraint as per policy.</p> <p>90 days</p>

independence and safety.		records relating to the environmental restraint relating to: organisational responsibilities and strategies; clinical justification for the use of restraint; documentation of residents' restraint assessments and evaluations and informed consent for the use of the lock.		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.