

# Sound Care Limited - Mercy Jenkins Rest Home

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## 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 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:

**Legal entity:** Sound Care Limited

**Premises audited:** Mercy Jenkins Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 13 December 2016 End date: 14 December 2016

**Proposed changes to current services (if any):** The facility is being sold and this provisional audit is being undertaken to establish the prospective owner's preparedness to provide a health and disability service and the current level of conformity with the required standards.

**Total beds occupied across all premises included in the audit on the first day of the audit: 27**

# 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.

## General overview of the audit

Mercy Jenkins is a 41 bed facility for residents requiring rest home and secure dementia care. The Taranki District Health Board (TDHB) stated they have issued an exit notice for all contracts but the date of exit has been extended awaiting the outcome of the intended purchase. The facility is currently owned by Kiwi Family Otago Limited.

This provisional audit was undertaken to establish the prospective owner's preparedness to provide a health and disability service and the level of conformity with the required standards for both rest home and dementia care services. The audit was conducted against the Health and Disability Services Standards and the provider's contracts with the TDHB. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau, management, staff, a general practitioner, the TDHB portfolio manager, current provider and the prospective owner.

The current owners had an urgent issue based audit in November 2016 undertaken by HealthShare Limited. Compliance related to these findings are being reported on by the temporary manager to the TDHB. At the time of audit, there was a TDHB appointed

temporary manager in place in accordance with section A22.2 of the Age Related Residential Care Service agreement. The general manager from Kiwi Family Otago Limited was also present at the audit.

As a result of this audit, there are 17 areas identified as requiring improvement. These relate to privacy, open disclosure, advance directives, staff signatures in progress notes, interRAI assessment documentation, assessment and planning information, medication management, food services, complaints management, evaluation of quality data, corrective action planning, incident and accident follow up, human resources management, plant and equipment, outdoor areas, emergency management, and call bells. The corrective action required related to assessment and planning is rated as a high risk and has been reported to the Ministry of Health, as required.

## **Consumer rights**

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Overall, services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were respectful and caring when interacting with residents.

Bicultural care is guided by a comprehensive Maori health plan and related policies. Staff have received training in best practice, however there are currently no residents who identify as Maori at this audit. Residents have care plans which details any specific needs in relation to cultural values and beliefs. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective by family members interviewed. There is access to formal interpreting services if required.

The service has links to a range of specialist health care providers, primarily based in New Plymouth, which contributes to ensuring services provided to residents are of an appropriate standard.

The service has a documented complaints management system which is implemented. All complaints sighted had been addressed within required timeframes. The general manager stated there were no outstanding complaints. The temporary manager confirmed there had been several complaints made to the TDHB which resulted in her placement at the facility but no evidence of these complaints was sighted on the days of audit. The perspective owner is aware of the current situation and reported that they fully understand the complaints process.

## **Organisational management**

The service has a business and quality plan in place. The organisation's mission statement, goals and philosophy as currently documented will be continued in the interim by the prospective owner to ensure residents' needs continue to be met. The prospective owner has developed a transition plan which identifies the new governance structure, organisational chart, staffing and training, policies and procedures, maintenance planning, and a marketing plan. This includes a proposed name change from Mercy Jenkins to Eltham Care Rest Home.

The prospective provider has aged care management experience. She has no plans to change staffing but improvements are planned to systems and processes as indicated in the transition plan. Staff, residents and family/whānau will be made aware of the upcoming change of ownership, should the change of ownership occur. The prospective owner was present on the first day of audit and has been made aware of the audit findings.

The current documented quality and risk systems and processes will continue to operate, but the prospective owner will introduce their own quality assurance programme over time. The current quality management systems include identification of hazards, staff education and training, an internal audit process, complaints management, and data gathering and reporting of incidents/accidents, restraint and infections.

Human resources management processes and the current documented staff education will continue to be offered. The prospective owner is an assessor for a recognised age care education programme and is experienced in aged care management. She verbalised a clear understanding of good human resources requirements. This is reflected in the transition plan sighted.

Existing staff will be given the opportunity for continued employment including the current RN. The prospective owner, who is a registered nurse with a current practising certificate, will be taking the role of clinical manager.

## **Continuum of service delivery**

The organisation works with the local Needs Assessment and Service Co-ordination Service to ensure access to the facility is appropriate and efficiently managed for the two levels of care offered. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission. The most recent admission occurred some months prior to this audit, to the level of care no longer offered by the service.

Residents' needs are assessed by the medical and registered nurse at the time of admission and within the required timeframes. There is presently one registered nurse, a TDHB appointed temporary manager, and the general manager of the Kiwi Family Care Ltd group, providing clinical leadership to a team of care and domestic staff. They are on duty or on call out of hours to support care staff. Shift handovers and communication sheets guide continuity of care. A general practitioner visits weekly and as required. A podiatrist visits regularly.

Care plans are developed based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files sampled demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis, however information included is not always consistent to reliably guide care. Residents and families interviewed reported being well informed and involved in care planning and evaluation through the annual review and they are satisfied with the care provided. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The activities programme provides residents with a variety of meaningful individual and group activities which maintains links with the local community. The planned activity programme for the rest home is overseen by a trained diversional therapist with a second therapist and care staff providing a more limited group programme in the dementia unit. The focus here is on the individual's participation. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using unit dose packaging system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with any special needs catered for. Policies guide food service delivery undertaken by staff with food safety qualifications. The kitchen was well organised and suitably equipped. Residents spoken to were generally satisfied with the meal service.

## **Safe and appropriate environment**

Services are provided in an environment that is appropriate to the level of care provided. There are amenities to meet residents' needs and to facilitate independence. Residents, visitors and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery.

There are adequate numbers of toilets, showers and bathing facilities.

Documentation identifies that processes are maintained to meet the requirements of the building warrant of fitness. Planned and reactive maintenance is documented.

Systems are in place for essential, emergency and security services. Six monthly emergency evacuation drills have occurred.

All residents have access to outdoor areas.

The prospective owner has included a preventative maintenance schedule in the transition plan sighted and is aware of the findings on the days of audit. She has no plans to make environmental changes to the facility footprint as she is not purchasing the building. The building will be rented from the existing owners.

## **Restraint minimisation and safe practice**

Restraint minimisation and safe practice policies and procedures reflect current good practice and meet legislative and Health and Disability Services Standard requirements. Staff education related to restraint management occurred in January 2016 and challenging behaviour in July 2016. At the time of audit, the service is restraint free with one enabler in place.

## **Infection prevention and control**

The infection prevention and control programme, which aims to prevent and manage infections, is presently led by the general manager of Kiwi Family Otago Ltd. She has undertaken on line training for the role of infection control coordinator. Infection control is an agenda item at the monthly staff meetings where infection rates are discussed. Specialist infection prevention and control advice is able to be accessed from the TDHB team or laboratory staff. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, guided by relevant policies and are supported with regular education.

Aged care specific infection surveillance is undertaken, results trended, and a summary report provided to the quarterly clinical governance meeting of the group. Follow-up action is taken as and when required.

## 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	32	0	8	4	1	0
<b>Criteria</b>	0	76	0	10	6	1	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>Mercy Jenkins Care has generic policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed to communicate respectfully, encourage independence, provide options and endeavour to maintain dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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 Moderate	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, and influenza immunisations. Staff were observed to gain verbal consent for day to day care on an ongoing basis.</p> <p>Advance care planning, establishing and documenting enduring power</p>

		of attorney requirements and processes for residents unable to consent is documented where relevant in the resident's record, although there is confusion between documents for resuscitation decisions and advance directives, noted in several files, including for residents in the dementia unit. These documents do not adequately guide staff on the actions they should take.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a pack with a copy of the Code and information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures are available at the entrance. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maintain links with their family and the wider rural community by attending a variety of organised outings, visits and van rides, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends who were seen to visit freely during the audit. Two family members commented that they felt welcome to visit at any time and were comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The service has a complaint register which shows that processes are managed according to policy timeframes. The general manager confirmed that complaints are also reported to head office. Staff, residents and family/whānau understand the complaints procedure and have access to complaints forms. All complaints sighted had been resolved in-house. This is confirmed in the complaints register sighted which showed the complaint made and the date it was lodged. No complaints were logged for April through to July 2016.  At the time of audit, the Taranaki District Health Board (TDHB) are managing several complaints made against the current organisation and this has resulted in the placement of a temporary manager on the

		25th November 2016. The auditors did not sight the complaints under investigation by the TDHB as they were not presented on the days of audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed were all longstanding in the facility. While they do not recollect being informed about the Code at the time of admission, a session about privacy and rights has been provided in the past year. The Code is displayed in public areas together with information on advocacy services, how to make a complaint and a feedback form. The prospective provider is presently working in a clinical role in the aged care sector and has a good understanding of the requirements of the Code
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	PA Low	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Although staff understood the need to maintain privacy, including sharing resident information within the facility, there was an example in which resident privacy and dignity was not maintained during personal care. Resident information is held securely and privately. All current residents have a private room (there is one unoccupied double room).</p> <p>Residents are encouraged to maintain their independence by participation in activities in and out of the facility and in self-care within their current abilities. Each plan includes an assessment of the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records. There are no reported examples of abuse or neglect occurring. Review of records</p>

		of two residents who had formed an attachment demonstrated that this was being managed sensitively, with the wellbeing of both parties considered.
<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>	FA	There are no residents who identify as Maori who require staff support to integrate their cultural values and beliefs. There is a current Maori health plan developed with input from cultural advisers. Current access to resources include the contact details of local cultural advisers. Guidance on tikanga best practice is available and has, in the past been supported by staff who identify as Maori.
<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	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences were included in all care plans reviewed (eg, shower times). A resident satisfaction questionnaire has been undertaken but has not yet been evaluated to determine how well residents' preferences are recognised and met (see also 1.2.3.8).
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe and secure in the facility. Staff have received course related education related to boundaries and expected behaviours. The registered nurse has records of completion of the required training on professional boundaries. Ongoing education has been provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
<p>Standard 1.1.8: Good Practice</p>	FA	The service encourages and promotes good practice by accessing services such as input from external specialist services and allied

<p>Consumers receive services of an appropriate standard.</p>		<p>health professionals, services for older people, wound care specialist, community dieticians, psychogeriatricians and mental health services for older persons. The general practitioner (GP) confirmed the service usually seeks medical intervention (see also comments 1.3.3.4).</p> <p>The general manager has provided group advice on infection control. Supporting infection prevention and control documents are consistent with recognised practices. Staff reported they have attended education sessions in New Plymouth. Other examples of a good practice environment observed during the audit included the initiation of a behavioural observation chart for a resident who is causing concern as a short term measure to assess the behaviours. Pressure injury management refers to a current wall chart to enable accurate assessment for grading purposes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>PA Low</p>	<p>Residents and family members stated they are informed about any changes to their/their relative's status and were advised about any incidents or accidents and outcomes of regular and any urgent medical reviews. The multidisciplinary team meeting held each year includes input from the resident and their family. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures, however, this was inconsistently implemented to meet the requirements of the Code.</p> <p>Interpreter services are able to be accessed via the Taranaki DHB services when required. Staff knew how to do so, although it was reported this was rarely required as all residents are able to speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>On the day of audit 27 beds are occupied consisting of 18 rest home level care and nine secure dementia care residents. The auditors were informed that one dementia care resident was reclassified as hospital level care by the Taranaki needs assessment coordination team, and was awaiting placement. However, apart from an entry in the resident's</p>

	<p>file stating family/whanau had been informed of the change of care level, there was no other documentation available on site to confirm this. Also the residents who have had their interRAI assessments updated by the needs assessment agency did not have paperwork available showing the updates. This could not be obtained on the days of audit. (Refer comments in criterion 1.3.3.3).</p> <p>The current service has a business plan which identifies the organisation's mission statement, vision and philosophy and shows the organisation's planning process. The prospective owner will use the existing business planning processes until she is well established in the service. She is aware that the direction and goals of the organisation need to be reviewed regularly and the transition plan presented clearly indicates the intended direction of the service. The prospective new owner understands the needs of the different certified service types and has an understanding of the Age Residential Related Care (ARRC) agreement, including in relation to the ARRC manager to meet section D17 of the agreement.</p> <p>The transition plan identifies areas of improvement the new owner/manager would like to introduce including ensuring there are adequate diversional therapy activities for all residents, the delivery of excellent and efficient food services, the introduction of a dedicated laundry person and ensuring staffing numbers are adequate to meet resident needs. The business will operate under Sound Care Limited trading as Eltham Care Rest Home. The new organisation chart clearly indicates how the service will be operated to meet residents' needs. The prospective owner/manager, who is a registered nurse with over two years' senior management experience, intends to actively work within the business as the owner/manager. She will commence in this role from the agreed date of takeover. The planned takeover date is January 2016.</p> <p>The quality programmes and procedures described in policy include hazard management, staff training and education, data reporting of incidents/accidents, infections, restraint and internal audit. The perspective owner proposes to introduce their own policies, procedures and quality assurance programme once staff are educated around the changes and can demonstrate knowledge of the quality programme requirements.</p>
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		Interviews with residents and family/whānau confirmed that their needs were met by the current service. They have yet to be informed of the pending change of ownership.
<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>	FA	<p>There have been three different facility managers in place in as many months. The service currently has a temporary manager appointed by the DHB to oversee services. She is an experienced registered nurse with many years' experience in aged care management. At the time of audit, the general manager from Kiwi Family Group, who is also a registered nurse with many years aged care experience, is undertaking the role of facility manager on a temporary basis. There is a recently employed registered nurse who works five days a week to include weekend cover. He is inexperienced within the New Zealand health care system and is being mentored by the two senior managers. The general manager stated they use staff from their other facility to cover as required.</p> <p>The prospective owner confirmed they will ensure a process is in place to cover senior management leave as appropriate.</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>	PA Low	<p>The service has a business plan and quality and risk processes in place which cover all aspects of service delivery. A risk plan is in place for 2014-2016 along with quality and risk policies and procedures. The quality planning identifies goals and objectives which are measured at organisational senior management level. This includes key components of service such as complaints management, infection control, health and safety, restraint and human resources management. Quality data collection occurs monthly and is reported to head office quarterly. Non-conformance details are shown in the organisational senior management minutes. Corrective actions sighted for accidents and incidents are inconsistently recorded.</p> <p>The prospective owner understands the need for accurate reporting systems that can be understood by staff and easily audited. The interim planning process sighted identifies that an electronic aged care management system will be implemented. This information will be used</p>

		<p>to inform and improve services as required.</p> <p>The internal audit system is one process used to measure achievement against the quality and risk management plan. Internal audits have not been fully completed as per schedule since August 2016.</p> <p>Internal audit results will be used by the prospective owner to measure progress of the service delivery. She states she will trend data so that unexpected changes in findings are responded to using corrective action procedures.</p> <p>Current policies and procedures sighted have been updated, and will remain in place for the interim and will be replaced when the new owner is fully established in the business. A rebranding exercise will occur with the name change going from Mercy Jenkins to Eltham Care Rest Home. This includes the Health and Safety policy which has been updated to reflect the current legislative updates.</p> <p>Actual and potential risks are identified and documented in the hazard register. Newly identified hazards show a risk rating and how they are to be managed. Staff confirmed their awareness of known hazards and that they understood and implemented documented hazard identification processes.</p> <p>The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these.</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>The general manager confirmed her understanding of statutory and/or regulatory obligations in relation to essential notification reporting to the correct authority.</p> <p>The proposed owner also confirmed her knowledge and understanding of this process. The prospective owner is aware of the issues identified in this audit and in the DHB issues based audit. She is able to verbalise knowledge and understanding of required follow up to meet legislative and DHB requirements.</p> <p>Staff interviewed stated they report and record incidents and accidents on a specific form. At facility level, there is a monthly register kept of</p>

		<p>all recorded accidents and incidents. Accident and incident reporting occurs three monthly to organisational senior management. Corrective actions shown on the accident and incident forms sighted are scantily documented with no evaluation of outcome. Refer also to comments in 1.2.3.8.</p> <p>Family/whānau stated they are notified of any adverse, unplanned or untoward events. However, this is not always clearly shown on the incident and accident forms sighted. Refer to comments in criterion 1.1.9.1 related to open disclosure.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>Human resources policies describe good employment practices that meet the requirements of legislation. More recently employed staff files (one Healthcare worker and one RN) show that they are police vetted upon employment, referees are checked and job descriptions clearly described staff responsibilities and an orientation/induction programme with completed specific competencies for their roles, such as medication management were located in the files. As per the recent DHB audit it is noted that staff files for those who have been at the facility for longer than six months do not show that all employment process have been completed. Staff that require professional qualifications have them validated as part of the employment process and annually.</p> <p>The prospective owner demonstrated awareness of good human resources employment practices.</p> <p>There is a staff education plan in place for 2016. The topics listed cover all aspects of service delivery. Education and training undertaken by staff was located in staff files and on education/training record forms. The content of education offered is identified, and whilst much of the education is based on policy content, guest speakers, such as from Tui Ora for cultural awareness and fire training by an off-site provider, is also noted. The general manager stated that as the facility is located rurally it is not always easy to find guest speakers to attend staff training. Staff confirmed during interview that they are offered in-service and off-site education related to their roles. No specific examples were given.</p>

		<p>Resident and family/whānau members interviewed identified that services are delivered in a manner that meets their needs. No negative comments were voiced during interviews on the day of audit.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented process to meet contractual staffing requirements. Rosters sighted identify that from 5 December 2016 staff who were no longer working at the facility had been removed from the roster. This was undertaken at the request of the temporary manager as a follow up to the unannounced DHB audit which was undertaken in November. The roster shows that there is a registered nurse available on morning shift seven days a week and on call as required. This reflects a recent roster change made by the temporary manager. All shifts are covered by a staff member with a current first aid certificate and staff who work in the dementia care unit either hold or are working towards recognised dementia care qualification.</p> <p>There are two diversional therapists who undertake activities Monday to Friday. The diversional therapist who works in the dementia care unit from 1pm to 3pm performs care giving tasks in the morning. There are two job descriptions in her file.</p> <p>During interview, clinical staff reported that they have sufficient time and staff to complete their required duties. The cleaner felt the hours worked did not allow full cleaning cover of the facility and stated that there was only four hours per week allocated to cleaning in the dementia care unit; the other hours are dedicated to the rest home. The cleaner works Monday to Friday from 9am to 1pm. Weekends and public holidays have no dedicated cleaning staff. Laundry is carried out by care staff as part of their daily duties. This was confirmed by the general manager who said care staff were also tasked with undertaking minimal cleaning duties, such as emptying the rubbish bins on the days no cleaner was rostered.</p> <p>The prospective owner intends to maintain the current staffing levels with additional cleaning hours and a review of activity hours. This is documented in the proposed roster sighted. She confirmed her awareness and understanding of the required skill mix to ensure rest home and dementia care residents needs are met. She is aware that</p>

		dedicated staff in the dementia unit cannot leave the unit unattended to assist staff in the rest home area. She is an assessor for a recognised age care qualification authority and intends to ensure staff hold appropriate qualifications to meet contractual requirements.
<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>	PA Low	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in nine clinical files sampled. Clinical notes were current and organised into a logical order. There is a section for medical notes and correspondence as well as for nursing assessments, care and progress notes. Records were legible with the name and designation of the person making the entry identifiable. However, there were examples in which progress notes and other clinical records did not consistently include the full signature and/or designation of the staff member where this is required. On occasion, first names only are used or the staff member initials.</p> <p>Records are collated into a single file at discharge. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. Archived records are held securely on site and are readily retrievable.</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>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents are mostly drawn from the local rural area. The resident and their family/whānau are provided with written information about the service and the admission process. The organisation seeks updated information from (NASC and the GP) for residents accessing respite care.</p> <p>Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, using an escort as appropriate. Hard copy documentation is used to transfer key information to the next service and to facilitate transfer of residents to and from acute care services. Open communication between services, the resident and the family is encouraged in these circumstances. At the time of transition between services, appropriate information, including medication records and, in one example, a detailed activities plan had been provided for a resident with dementia. Staff reported that this had been useful in developing an individualised plan of care. All referrals are documented in the progress notes. A family member interviewed described being kept informed about their relative by the service during a hospitalisation.</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 management policy is current and identifies all aspects of medicine management. The Medicines Care Guide for Residential Aged Care is available on the medication trolleys for the rest home and dementia service.</p> <p>A safe system for medicine management using a recognised blister packaging system was observed in use on the days of audit. Interview with the prospective purchaser indicates the intention to move to an electronic system following the sale. The staff observed during the audit demonstrated a clear understanding of their roles and responsibilities related to each stage of medicine management. Photo identification of residents is current. Allergies or adverse drug reactions are consistently documented. A list of medicines able to be crushed is available in the administration folder. Staff are assessed for competency prior to being signed off to complete the administration process. Records sighted confirm that competency is reviewed annually.</p> <p>Medications are supplied to the facility from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. A pharmacist visits the site and returns any out of date or pharmaceutical items which are no longer required.</p>

		<p>There are systems to ensure controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration when in stock. The controlled drug register provided evidence of weekly and six monthly stock checks. However, there is a discrepancy between the register and stock on hand noted. The records of temperatures for the medicine fridge were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart. There were no examples of verbal orders in the files sampled.</p> <p>There is one resident who self-administers medications at the time of audit. Assessment of competency to undertake self-administration for this resident is on record. Appropriate processes are in place to ensure this is managed in a safe manner. There is a limited list of medicines approved to be self-administered.</p> <p>Medication errors are reported to the registered nurse and the event recorded on an accident/incident form. The resident and/or the designated representative are advised of any errors although no errors have been reported in the recent past (see also comments re 1.1.9.1.) There is a process for review of any medication errors, and trends are discussed at the monthly staff meeting.</p> <p>Standing orders are used, are current and comply with guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management 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 is provided on site by two cooks and rostered kitchen hands. A care staff member is assigned to reheat the prepared evening meal in the afternoon. The menu is in line with recognised nutritional guidelines for older people, follows summer and winter seasonal patterns and has been reviewed by a qualified dietitian in May 2016. Recommendations made by the dietician have been implemented. The cooks have undertaken an approved safe food handling qualification, with all kitchen assistants also completing a basic food handling</p>

		<p>course.</p> <p>Most aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines, however, there are some deficits in relation to temperature monitoring, stock levels and cleanliness. The service has not yet developed an approved food safety plan. End of cooking temperatures are recorded for meat/fish items, for the main midday meal. Chopping boards are in need of replacement.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents requiring nutritional supplements have these provided on registered nurse, dietician or medical request. Records of any variances from the standard menu are maintained in a notebook. Residents in the secure dementia unit have access to extra food and fluids at all times to meet their nutritional needs. Special equipment, to assist residents to eat independently is available.</p> <p>The resident and family members interviewed expressed satisfaction with the meal service, although one resident was vocal and negative about the presentation of the meal during the audit. A survey of residents has been undertaken but evaluation of the data, including for the food service, is yet to occur (See 1.2.3.8). Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring individual assistance had this provided. There is a minimum of two staff on duty in each dining areas at meal times, although one is engaged in a medication round in the rest home during the evening meal period.</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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in</p>

		consultation with the resident and whānau/family. An example of this had recently occurred, with the resident reassessed and currently awaiting transfer to a higher level of care. A clause in the access agreement relates to when a resident's placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as (pain scale, falls risk, skin integrity, cognition and nutritional screening), as a means to identify any deficits and to inform care planning. These assessments are completed in addition to the six monthly interRAI reviews.</p> <p>In a sample of care plans reviewed, there is comprehensive information available to inform the development of a relevant plan of care, although this is not always aligned with the assessment results or the deficits triggered on interRAI (eg, a cardiovascular deficit does not have an associated plan in place) (see Corrective Action 1.3.3.4). InterRAI assessments have been undertaken for all residents at entry as required in the ARRC contract, however reviews are lagging, necessitating support from NASC to complete those overdue up to the end of November 2016 (see Corrective action 1.3.3.3). The registered nurse is undertaking interRAI training.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The plans reviewed are very detailed, with some generic components evident in the files sampled. These are not consistently individualised to reflect the support needs of residents, or the outcomes of the integrated assessment process and other relevant clinical information (see comments 1.3.3.4).</p> <p>Progress notes, activities records, medical and allied health professionals' notations are all clearly written, informative and relevant. Any change in care that is required is documented by the registered nurse and verbally passed on to relevant staff. Examples include additional weight monitoring, behaviour monitoring and introduction of new medication and food supplements. Residents and families reported participation in the development and ongoing evaluation of care plans through the annual review with the team.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews with residents, staff and the GP verified the provision of care to residents was consistent with their needs in spite of some conflicting care plan information. The attention given to meeting a diverse range of resident's individualised needs was evident, with staff focussed on providing each resident with a quality of life that they find satisfying. The GP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. The detail and usefulness of information provided to the GP out of hours is noted (see 1.3.3.4). Care staff confirmed that care is provided as requested by the registered nurse and that they do refer to the plan of care after days off to identify any changes which have occurred.</p> <p>A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by two trained diversional therapists holding the National Certificate in Diversional Therapy. They work independently and plan different programmes for their own area. The facility has a van for outings.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The therapists are able to describe how changes and variation has been added to the programme. The resident's ongoing activity needs are reviewed as part of the formal six monthly care plan evaluation.</p> <p>The planned monthly activities programme operates Monday – Friday. It matches the skills, likes, dislikes and interests identified in assessment data for rest home residents. Activities reflect ordinary patterns of life and include community activities and engagement where possible. Individual, group activities and regular events are offered and were noted to be well attended during the audit. Examples include bingo, entertainment, music and quizzes. Visitors also</p>

		<p>participated alongside the resident. Residents interviewed confirmed they find the programme sufficiently interesting and participate as they feel inclined. There are quieter areas available away from the main lounge for residents who do not wish to participate in a particular activity.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Although formal activities are offered at times when residents are most physically active and/or restless, in general, activities are flexible and undertaken one on one or as small group by care staff. This includes walks in the grounds and on occasion, van outings. The activities coordinator works as a care staff member in the morning and spends two hours on the programme each afternoon. Care staff keep a record of any activities they undertake with a resident.</p> <p>Staff can access a range of activity resources throughout the day (or night) and were seen to make use of these. The unit was not at full occupancy, but was noted to be generally calm (a low stimulus area is available), the residents settled with quiet background music and sufficient space for residents to spend time alone if they wished. An outdoor area is under repair with restricted access due to recent damage caused by a fallen tree.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse on duty or on call.</p> <p>Formal care plan evaluations occur every six months together with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the registered nurse and progress updated by care staff in the progress notes. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were seen, including those developed in response to new problems, an increased need for monitoring (eg, a new urinary infection, weight loss or changes in behaviour). Progress is evaluated as clinically indicated with residents noted to be medically stable reviewed three monthly by</p>

		<p>the GP, or at least monthly if not stable. There were examples of weekly reviews for residents with compromised health.</p> <p>Other plans, such as wound management plans were evaluated and updated each time the dressing was changed. Response to a changed medication regime was also evaluated for effectiveness and progress well documented. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a regular general practitioner available from the local practice, residents may choose to use another medical practitioner, although this seldom occurs. If the need for other non-urgent services are indicated or requested, the GP undertakes a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to outpatient clinics and diabetes service. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. One resident has been referred to another residential service following reassessment as requiring a higher level of care than that offered at Mercy Jenkins Care facility.</p> <p>Any acute/urgent referrals are actioned immediately and if directed by the GP, such as accessing the ambulance service for urgent transfer to the accident and emergency department.</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>All chemicals are securely stored. Chemicals are labelled and safety data sheets are available. Regular waste bin pick-ups occur by a contracted company. Waste management meets legislative requirements.</p> <p>Staff confirmed that they can access personal protective clothing and equipment at any time. As observed, disposable gloves are worn when required</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>	<p>PA Moderate</p>	<p>Documentation sighted identified that processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which was issued on 10 May 2016.</p> <p>Maintenance is undertaken by both the employed maintenance person and external contractors. For example, contractors were used to fill the holes in the driveway. Electrical safety test tags show this testing occurred in February 2016 and is valid until February 2018. Clinical equipment checking was due in October 2015. The large commercial dryer in the laundry has been out of action for over a year. The general manager stated this would be removed prior to take-over.</p> <p>Generally, the physical indoor environment minimises the risk of falls and promotes safe mobility by walking areas not being obstructed or cluttered. One bathroom area has vinyl on the floor that has split apart and could pose a tripping hazard. One window in the dementia unit has a missing window catch and during the walk around it was noted that the top of the wall heaters in the hallways have various degrees of rust some are worse than others.</p> <p>The service documents the day to day requested maintenance which occurs. The maintenance request book is signed off when jobs are completed.</p> <p>There is an easily accessed shaded secure outdoor area for dementia resident use. A recent storm uprooted a tree in this area and damage caused to the resident access ramp, veranda area and the roof was being repaired by outside contractors on the days of audit. All health and safety requirements, such as having the work area securely fenced off were visible. This damage has also created chipped paint work on the exterior walls. This work should be completed by the time of the proposed takeover. A temporary ramp has been put in place which allows residents to use the outdoor area. The outdoor areas for rest home residents are easily accessible.</p> <p>Multiple maintenance issues sighted were completed during the days of audit as follows:</p> <ul style="list-style-type: none"> <li>-the unpainted walls in two recently rebuilt rooms off the rest home</li> </ul>

		<p>lounge (one is now the staff room and the other a small resident area) were painted</p> <p>-there is a resident toilet off the small resident lounge which did not have a lock. This was installed.</p> <p>-multiple toilet areas had wall coverings that were lifting at the edges exposing the walls to water damage and preventing appropriate cleaning along with exposed screw holes in the walls. These were filled and repaired.</p> <p>-one toilet which kept running was fixed and a rusty toilet roll holder was removed.</p> <p>-one toilet which was extremely badly stained was cleaned.</p> <p>-areas behind the toilet cisterns were repainted to enable them to be cleaned to meet infection control standards of cleaning.</p> <p>-a missing light shade was replaced.</p> <p>-three dining room tables in the dementia care unit were chipped to show exposed wood. The general manager stated they had new replacement tables in storage which would be placed in the dementia care unit when she was able.</p> <p>Interviews with residents and family/whānau members confirmed the environment was suitable to meet their needs.</p> <p>The prospective owner is not purchasing the building but is aware that ongoing internal decoration and maintenance will be her responsibility. This is identified in the maintenance plan shown in the transition plan sighted.</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>	<p>FA</p>	<p>Two of the residents' bedrooms in the care facility have ensuite toilet facilities. There are adequate numbers of centrally located shower and bathroom areas in both the dementia and rest home areas. Designated staff/visitor toilets are available.</p> <p>As identified in standard 1.4.2 bathroom repairs were undertaken on the days of audit to meet required standards. Outstanding repairs to one bathroom are described in criterion 1.4.2.4. This issue was placed</p>

		<p>on the maintenance schedule for repair.</p> <p>Monthly monitoring of hot water temperatures in residents' areas shows that these remain within a safe range for aged care facilities.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></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. Bedrooms are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings. All bedrooms being used at the time of audit are single occupancy. There is one bedroom in the rest home area which the general manager stated is designated as a double bedroom and there are two beds in the room. This room is currently being used for storage. This room has a false wall which blocks off a disused shower area. The general manager stated this shower had been decommissioned. Refer comments in criterion 1.4.7.5.</p> <p>In the dementia care unit one bedroom is used as a quiet area for residents and this does not contain a bed. The general manager stated this room is included in the bed count for this area.</p> <p>Resident and family/whānau members interviewed did not identify any concerns related to personal bed space.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Residents are provided with adequate areas to meet their relaxation, activity and dining needs. The dining and lounge areas are separated by placement of furnishings. The areas are appropriately furnished to meet residents' needs. Refer comments in standard 1.4.2 regarding the tables in the dementia care unit.</p> <p>Residents and family/whānau voiced their satisfaction with the environment and one relative stated that 'the views from the facility are wonderful'.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p>	FA	<p>There are secure storage areas for cleaning and laundry chemicals. As discussed with management on the days of audit, the laundry door</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>needs to be kept locked when staff are not in attendance. Refer comments in Standard 1.2.8 related to cleaning hours and Standard 1.3.13 regarding kitchen cleaning. Laundry and cleaning tasks are documented.</p> <p>The laundry has a designated clean and dirty area. The laundry operates seven days a week and is undertaken as part of caregiver daily duties. The large industrial dryer which has not been in service for over 12 months is to be removed by the current owners.</p> <p>Residents and family/whānau members interviewed had no negative comments related to cleaning or laundry. The auditor noted that upon entry to the facility urine could be smelt. This was prior to daily cleaning commencing and was not evident at the end of the day.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>Staff receive emergency training during orientation and updates are presented annually (last presented in February 2016). Six monthly fire evacuation drills are carried out but the trial evacuation undertaken in August, by an outside trainer, stated it was not done very well and that further staff education was required. The temporary DHB manager stated that she is organising further education for staff and she was waiting for a date for this to be undertaken by a member of the fire service. Fire equipment is checked and maintained by an off-site provider. There is a fire service approved fire evacuation plan dated June 2010. The general manager confirmed that there had been no changes to the building footprint since this time and that the internal work that had been undertaken did not require any changes in the existing fire cells.</p> <p>Emergency supplies and equipment include water. There was some emergency food stored away from the kitchen but it was minimal and no evidence of regular checking could be seen. During discussion with the general manager it was decided that the kitchen carried enough food for emergency use and that the emergency food stores would remain in the kitchen. Refer comments in 1.3.13.3.</p> <p>Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and gas cooking.</p>

		<p>Staff are required to ensure all doors and windows are secured after hours. On the first day of audit the exit gate from the secure garden area in the dementia care outdoor area could not be opened owing to the bolt being rusted in place. The gate is to be used for emergency exit if required. This was rectified at the time of audit so the gate could be opened. Not all staff were aware of where the key to the padlock on this gate was kept. It is carried on the keys held with the senior staff member. The general manager stated she will provide immediate education to staff to ensure all staff who work in the unit are aware of where to find the key.</p> <p>The door which was installed for the psychogeriatric unit has a key code lock on it. This has remained in place. Also, the exit door to a rest home level care outdoor area has a punch key code lock for exit.</p> <p>Staff and residents interviewed confirmed they feel safe at all times.</p> <p>There is a call bell system available for residents and staff to call for assistance if required. The double bedroom only has one working call bell.</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>	<p>FA</p>	<p>The facility has appropriate heating throughout the year. (Refer comment in 1.4.2.1 regarding the need to repair rust on wall heaters). The maintenance person stated that the boiler system in place to provide heating is only a year old. Doors and windows are opened to ensure ventilation.</p> <p>All resident areas have at least one opening window. The double bedroom has had one window permanently closed off as it would open into a lounge area. However, there is still one window which opens. This opening window is onto the recently developed resident court yard where all the cigarette butts were found. The general manager stated that this is no longer a designated smoking area and that the butts must have been there for some time. (Refer .4.2.6) The service has a designated smoking area for residents which does not impinge on other resident areas.</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>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. There is no infection control resource person in the absence of the general manager, however, the registered nurse provides guidance and can contact the on call senior staff member if necessary. Infection control management is outlined in a current infection control manual which has been developed at group level. The infection control programme has been reviewed annually.</p> <p>Presently, the group manager is the designated IPC coordinator. Roles and responsibilities are defined. Infection control matters, including surveillance results, are discussed monthly (raw numbers) at the staff meeting, and tabled at the Group quarterly clinical governance meeting.</p> <p>The potential new owner/manager currently undertakes the role of infection control coordinator and will assume this role at the new facility.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. There have been no reported outbreaks in the facility since the previous full audit. The infection control manual provides guidance for staff on all relevant aspects of infection prevention and control</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>	<p>FA</p>	<p>The general manager is a registered nurse presently fulfilling the infection prevention and control coordination role. She has the skills and knowledge for the role. Most recently, she has completed a three-hour on line training via "Learn online" covering hand hygiene, personal protective equipment (PPE) and environmental management, with a certificate of completion on file. With further registered nurse capability, it is intended that the role is devolved to the facility level.</p> <p>There are established local networks with the infection control team at the DHB and expert advice from the community laboratory is available if additional support/information is required. The infection control coordinator has access to residents' records and diagnostic results to</p>

		<p>enable timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p><b>Standard 3.3: Policies and procedures</b></p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2015 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, correct hand-washing technique and use of disposable aprons and gloves, as appropriate to the activity. There are adequate supplies of personal protective equipment for general use and in the event of an outbreak. Alcohol based hand rubs stations are located throughout the facility and suitable hand washing basins, including in residents' rooms. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Staff who have completed the National Certificate in Health, Disability, and Aged Support (L3) have a unit standard included which covers essential infection control practice. Education is also provided by DHB registered nurses, and the infection control coordinator. An infection prevention and control quiz has been developed and covers the essentials of the programme including use of personal protective equipment. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>Examples of responsive staff education are sighted in the staff meeting minutes reviewed in response to an increase in the incidence of urinary tract infections in October 2016. There have been no recent outbreaks</p>

		<p>reported.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing and advice about increasing fluids during hot weather.</p>
<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance activities undertaken at Mercy Jenkins reflects the monitoring recommended for long term care facilities. Infection definitions reflect a focus on symptoms rather than laboratory results. These include urinary tract, skin, eye/ear, gastro-intestinal, and upper and lower respiratory tract and "other". When an infection is identified, a record of this is documented in the clinical record. There are recent examples of short term care plans being developed in response to an infection. The registered nurse (in the first instance) and infection control coordinator reviews all reported infections.</p> <p>Monthly surveillance data is collated and recorded numerically (raw data). There is limited analysis of the data (see also comments 1.2.3.6) to identify any trends, possible causative factors or required actions. As an example, a spike in infections in September/October indicated that one resident was implicated in three infections. The other four were unrelated, however the likelihood of one resident having an unsuccessfully treated infection (rather than three separate and new episodes) had been overlooked.</p> <p>A summary of surveillance activity is recorded in a log and reported to the clinical governance group and compared with other facilities in the group. There are no data comparisons undertaken for the dementia resident group. The current system makes it difficult to undertake sector comparisons for rates of infection.</p> <p>Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p>	FA	<p>There are policies and procedures in place to guide staff in the safe</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>use of restraint. Policy identifies that the use of enablers is voluntary and should be the least restrictive option to meet the needs of the resident to promote independence and safety. At the time of audit there are no restraints in place and one bedside rail which is being used as an enabler.</p> <p>Staff confirm that no restraint is used and this is also identified in meeting minutes sighted. Restraint minimisation education was presented in January 2016 and July 2016 education covered challenging behaviour management.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	<p>PA</p> <p>Moderate</p>	<p>There are a number of different forms used to record resuscitation decisions, including a decision tree, reference to end of life family considerations and advance directive forms. Enduring power of attorney records are held on file for residents in the dementia unit, and for some residents in the rest home, including records of when these have been activated. Some residents have an advance directive in place prior to losing capacity to make an informed decision.</p> <p>In one example sighted, the resident's competency was assessed by a clinical psychologist in 2014 and the resident deemed not to be competent. However, the advance directive</p>	<p>Documentation in relation to resuscitation wishes and advance directives is confusing. Status of the resident to make a valid decision is unclear in the current documentation formats.</p>	<p>Review the current documentation and update this to ensure advance directive and resuscitation decisions are clearly documented.</p> <p>90 days</p>

		<p>document was signed by the GP in 2016 indicating the resident is competent to make a directive. A second file example also had variable and conflicting documentation. Another resident had a directive made prior to entry to the dementia unit. This had not been reviewed in response to changed capacity and involvement of the individual holding Enduring Power of Attorney. Further discussion with staff and review of files indicates there are other vulnerable residents for whom competency has not been determined in a timely manner when cognitive changes are recognised by staff. Interview with the GP confirms that this information needs to be more clearly documented to identify where advance directives are valid and the resident's competency status be readily identifiable.</p> <p>Overall the documents sighted are confusing and potentially misleading for staff when determining the decision making capacity, resident's resuscitation decision and the actions to be taken.</p>		
<p>Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>There is a complaint register in place. It shows what the complaint was, the date received and the date a response was sent. The complaints sighted were signed off as completed by management. For example, three complaints were sighted related to</p>	<p>One complaint received related to two issues (one issue is about the pot-holes in the drive and the other is about food services). No evidence could be found that the issue related to food had been addressed nor was it acknowledged in the response letter</p>	<p>Provide evidence that all complaint documentation is completed and that all issues identified in a complaint are responded too.</p>

		<p>pot-holes in the driveway. These have now been filled in by a contracted company.</p> <p>The data sighted does not show the actions taken to resolve complaints and one complaint related to two issues only shows one was addressed. The general manager stated she had never been made aware the complaint related to two issues.</p> <p>The temporary manager was made aware of an issue regarding two residents by the DHB portfolio manager but no documentation was found related to this at the time of audit. It is uncertain if a complaint was made or not.</p>	<p>sent to the person who made the complaint. No evidence was available related to the complaints leading to the DHB issues based audit.</p>	<p>90 days</p>
<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	<p>PA Low</p>	<p>All current residents have single rooms, with a hand basin available, as well as communal bathrooms. Privacy for residents can be maintained in the showers and toilet areas in the rest home and dementia unit. Three residents in the dementia unit were observed being shaved by a staff member in the lounge area, with other residents and staff present.</p>	<p>Resident privacy and dignity in the dementia unit is compromised in that three male residents were observed to be shaved by staff in the lounge, with other residents and visitors present.</p>	<p>Maintain resident privacy and dignity during personal care activities.</p> <p>180 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from</p>	<p>PA Low</p>	<p>Open disclosure is recorded on the accident/incident reporting form and on occasion, on the family communication log where it occurs.</p>	<p>A sample of incident data for October 2016 (13 resident related incidents) recorded that family members had been contacted on four occasions.</p>	<p>Ensure the system for open disclosure following a resident adverse event is sufficiently detailed and</p>

service providers.		Some residents and families identify that they only wish to be contacted if the matter is serious and this preference is documented.	The remaining nine incidents have no indication of family contact being made, or the reason why this did not occur.	completed (eg, incident reports have the open disclosure section completed and includes the reasons that family were not contacted, as applicable).  180 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality improvement data is collected and analysed for key performance indicators. The process of data collection has not been kept up to date since August 2016. For example, whilst raw data is collected for infection control to show infection numbers there is limited analysis. (Refer comments in standard 3.5). Results of quality data information are shown in the meeting minutes sighted for senior management. Results are shared in graphs with staff at monthly staff meetings. However, no evidence could be found that this information is evaluated. The general manager stated this has not occurred as the result of frequent change of managers and her unavailability owing to sickness over the past few months.	No documented evaluation of data was sighted. Infection control data collected identifies the number of infections that occur but analysis is limited and does not clearly identify trends, possible causative factors or required actions. Not all the internal audits listed to occur have been completed for 2016.	Provide evidence that quality data evaluated to identify trends and that internal audits are up to date.  180 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard	PA Low	Corrective action requests related to accidents and incidents are reported three monthly to the general manager. Remedial actions shown are generic and do not show if the actions to be taken have been completed. The	Documentation related to corrective actions was difficult to trace to specific incidents and not all issues identified have a documented corrective action, such as complaints follow up (refer criterion 1.3.13.3) and the results of	Provide evidence that all issues identified have a corrective action put in place to show what actions are to be taken and by whom and

<p>or requirements is developed and implemented.</p>		<p>contributing factors and root cause analysis table sighted is a collective document and does not identify which incident information it relates to. When discussed with the general manager it was confirmed that required corrective actions are discussed at staff meeting but that they are not always well documented. Staff confirmed that required actions to improve services are discussed at meeting. Discussions are not shown in the meeting minutes sighted.</p> <p>There were two negative comments in the resident satisfaction survey but documentation was not located to show follow up was undertaken.</p>	<p>the resident satisfaction survey (November 2015).</p>	<p>by when</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>The service documents adverse events on specific accident and incident forms. However, in the incident forms sighted in the resident files reviewed, opportunities to improve service delivery are not always identified. Some of the accident and incident forms sighted do not have any documented evidence of follow up occurring prior to being signed off. For example, one medication incident which occurred in September 2016 has not been follow up. The accident and incident forms are not always completed.</p>	<p>As the data sighted on accident and incident forms is not always completed there is insufficient documented data to show if the information is used as an opportunity to improve service delivery.</p>	<p>Provide evidence of how service shortfalls are used as opportunities to improve service delivery.</p> <p>180 days</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 Low</p>	<p>Staff files reviewed (six) and documentation sighted shows that eight staff hold a qualification in dementia care and at least four other staff hold approved age care qualifications up to level three.</p> <p>The file for the maintenance person shows that since his employment in November 2012 the only education he has attended is hand washing. There is no job description, police check, application form, curriculum vitae, or employment contract. Reference checks were not available in three of the six files reviewed. Two of the six files reviewed did not contain up to date staff appraisals as is required to meet clause D17.7f of the Age Related Residential Care contract.</p>	<p>Procedures set out in policy regarding employment are not followed. Reference checking is not consistently undertaken, incomplete employment data is contained within staff files and performance appraisals are not all up to date. One staff member's file contained none of the required items.</p>	<p>Provide evidence that the appointment of service providers is undertaken according to current good practice requirements to safely meet the residents' needs. Annual staff appraisals are kept current to meet contractual requirements</p> <p>180 days</p>
<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	<p>PA Low</p>	<p>There is variability in the recording of the names and designation of service providers which is not in accordance with organisational policy. A list of sample signatures is maintained, however the progress notes sighted do not consistently include the full signature and/or designation of the staff member completing the entry. Initials are seen to be used in some entries in the controlled drug register where full signatures are required.</p>	<p>The name and designation of staff making entries in organisational records is not in accordance with policy or legal requirements.</p>	<p>Ensure all staff entries in clinical records and organisational documents are in accordance with policy or legal requirements.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p>	<p>PA Low</p>	<p>The controlled drug register contains</p>	<p>The controlled drug register balance</p>	<p>Complete actions to ensure</p>

<p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>an entry for a liquid medication. This indicates that the item had been returned to the Pharmacy, however this is unclear as the balance noted suggests the item is in stock. On inspection, there is no medication stored in the safe. It is reported that this anomaly is being addressed by the contracted Pharmacy.</p>	<p>for a liquid medicine does not match the stock on hand.</p>	<p>the controlled drug register entries are accurately recorded.</p> <p>180 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Moderate</p>	<p>Not all aspects of the food service meet requirements.</p> <ul style="list-style-type: none"> <li>- Chilled and frozen food delivered fortnightly by the supplier is not temperature checked on arrival.</li> <li>- There is no evidence that food reheated by care staff at the evening meal is temperature checked prior to serving.</li> <li>- Records of monitoring of the food fridge could not be located.</li> <li>- Pantry stocks and frozen food is available, but on the day of audit, the quantities of stock were at a low level prior to delivery, and were insufficient to provide adequate food supplies in the event of an emergency.</li> <li>- A kitchen cleaning schedule is in place and signed on completion, however on inspection, the kitchen is noted to have a build-up of dirt in corners and under benches.</li> <li>- Chopping boards have well-</li> </ul>	<p>Not all aspects of food procurement, storage and delivery, comply with current legislation and guidelines. There are limited food pantry stocks on hand at the end of the ordering cycle to provide suitable food items in an emergency. Chilled and frozen food is not temperature checked on arrival from the supplier; the evening meal reheated by care staff is not temperature checked prior to serving; and records of the kitchen fridge temperature monitoring could not be located. The kitchen has a build-up of dirt in some areas. Chopping boards are in need of replacement</p>	<p>Ensure all aspects of the food service comply with current legislation, and guidelines.</p> <p>90 days</p>

		worn surfaces		
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>There is one registered nurse employed at the facility, who is supported by the general manager and the current appointed temporary facility manager. This RN is undertaking interRAI training, but is not presently qualified to undertake assessments.</p> <p>The NASC team are reported to have visited the facility in the week prior to audit and updated five overdue interRAI assessments due up to and including November 2016. One of these residents is awaiting transfer to a higher level of care as sighted in the resident's file.</p> <p>A spread sheet indicates that there are seven reviews for December still to be completed, and a further four due in January 2017. An ongoing management schedule has been developed. The assessments completed by NASC are not currently available to facility staff to guide care planning or to evidence completion of overdue reviews. It is reported that the Needs Assessment service will support the organisation to achieve timely reviews until there is a trained and competent interRAI assessor available in the facility to complete the required reviews.</p> <p>The proposed purchaser of the facility</p>	<p>Evidence of updated interRAI assessments for a backlog of reviews recently completed by NASC are not available on site to guide care planning. A RN is still to complete interRAI training to address the eleven reviews due in December 2016 and January 2017</p>	<p>Ensure all interRAI reviews are completed within the required timeframes</p> <p>90 days</p>

		is a fully trained and competent interRAI assessor.		
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA High	<p>Nine residents' files sampled (four in the dementia unit and five in the rest home) have interRAI assessments on file to guide care planning. In addition, there are extensive nursing assessments contributing to a documented plan titled "Resident Centred Care Plan". (see also comments 1.3.3.3.)</p> <p>The links between assessment, planning, interventions and evaluation are poorly integrated and do not provide a coherent plan of care for each resident. The interRAI assessment does not consistently inform the development of the care plan and not all items triggered are apparent in the plans sighted. There are several discrepancies in care planning information noted in the files (eg, falls risk ratings, nutritional needs and pressure management). Updates from interRAI reviews are not consistently resulting in an updated resident care plan, leading to confusion for staff about the care required.</p> <p>There is conflicting information noted in five of nine plans sampled and a lack of individualisation to demonstrate resident centred care. For example, a resident with no deficit identified on the interRAI assessment</p>	<p>Inaccurate and poorly integrated assessment and planning information in the guiding care documents is seen in more than half the files sampled. The likelihood and consequence of this creates a high level of risk for care delivery to residents in the facility.</p>	<p>Implement effective systems which enables a coordinated approach in the documentation of care delivery in a manner that promotes continuity of care and a team approach where appropriate.</p> <p>30 days</p>

		<p>has a skin integrity plan which refers to the use of an alternating pressure mattress. This item is not in use, nor required, as the resident is independently mobile, with no skin integrity compromised.</p> <p>The GP interviewed expressed a lack of confidence in the detail of resident information provided by staff calling for advice out of hours. This was described as compromising clinical decision making about the urgency and necessity of an onsite medical review and had reportedly occurred on several occasions in the past year. There is no standardised communication tool implemented by the service.</p>		
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>Electrical safety checks are current. Building warrant of fitness checks are documented to meet legislative requirements. Whilst the staff confirm they use the maintenance request book to record work required they reported that they had been told not to record some issues, such as plumbing. This was discussed with the general manager on the day of audit who stated this was not the case. There is adequate clinical equipment with overdue testing dates.</p> <p>Windows in the secure dementia area lounges have security stays fitted to prevent them from opening too wide. One window in the lounge only has</p>	<p>Clinical equipment checks were due in October 2015.</p> <p>One window in one of the dementia care resident lounges has a missing window catch.</p> <p>Wall heaters throughout the facility are rusting.</p> <p>The bathroom vinyl in one bathroom is separating and poses a tripping hazard and cannot be cleaned to meet infection control cleaning standards.</p>	<p>Provide evidence that all buildings, plant and equipment comply with legislative requirements, is safe and fit for purpose</p> <p>90 days</p>

		one window catch. Wall heaters throughout the facility are rusting, with some showing more signs of rust than others.		
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>PA</p> <p>Moderate</p>	<p>There are outdoor areas for rest home residents and a secured area for dementia care residents. There are shaded areas for resident use.</p> <p>Plumbing repair work undertaken in the dementia care outdoor area is yet to be completed. This has resulted in a hole in the ground (approximately 500 millimetres deep) with only a wooden pallet covering the open hole. The pallet was easily removed on the day of audit. The general manager stated that owing to the age of the pipe work it is difficult to get pipes the same size as the existing ones and they have been waiting a long time for pipe repairs to be completed.</p> <p>One outdoor area for rest home resident use has cracked and uneven concrete and the outdoor furniture being used is inappropriate as indoor furnishings are being used and they have split coverings. This area also has cigarette butts in many places. There is a drain beside the ramp used to access this area which is open with only a board covering it. The board is not secure. It is also noted that the planter boxes are in a poor state of repair.</p>	<p>Furnishings used in one of the outdoor areas used by rest home residents has inappropriate furnishings which are in a poor state of repair. Cracked and uneven concrete, an open drain beside the walking ramp and cigarette butts are littered around the area.</p> <p>Incomplete plumbing work in the dementia care outdoor area has left an exposed hole in the ground which is covered over by an easily removed wooden pallet.</p>	<p>Provide evidence that the outdoor areas are safe and fit for purpose for residents to use.</p> <p>90 days</p>

<p>Criterion 1.4.7.1</p> <p>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>The facility has a fully sprinkler system and has fire equipment to meet building code of compliance. The hose reels and sprinklers are checked monthly. The fire extinguishers had not been checked within the last 12 months but this was rectified on the second day of audit. Staff are unsure of what should occur during a fire evacuation.</p> <p>Whilst the internal door in the rest home area has a key code lock which deactivates in the case of fire, if the door is closed at any other time during the day resident movement is restricted. There is also an exit door to the resident outdoor area in the same area which has a key code lock on it. When discussed with management on the day of audit they placed the key code number on each side of the internal door until this can be deactivated and stated they would put a normal door lock on the exit door to the outdoor area so rest home residents could access all areas easily especially in case of an emergency.</p>	<p>Comments sighted on the August 2016 fire evacuation drill indicated that the drill was not well done and that it was a “waste of time”. Staff on duty on the day of the August 2016 drill did not know what actions to take and a recommendation for further staff education and the training of fire wardens was noted. This is yet to be followed up.</p> <p>Key padlocks on two doors in the rest home area may restrict resident movement. (No environmental restraint is documented).</p>	<p>Ensure staff knowledge and training allows safe management of emergency situations and can be demonstrated during fire evacuations. Ensure rest home level care residents areas are not restricted.</p> <p>90 days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA Low</p>	<p>There is an audible call bell system throughout the facility. Call bells were responded to very promptly during audit. One double bedroom which has two beds in it but is not currently in</p>	<p>One bedroom which has two beds in it only has one working call bell.</p>	<p>Ensure all required call bells are in working order.</p> <p>Prior to occupancy days</p>

		use only has one working call bell. The call bell which is not working did not appear to be connected to the existing call bell system		
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.