

Te Ata Resthome Limited

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

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

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

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

The specifics of this audit included:

Legal entity: Te Ata Resthome Limited

Premises audited: Te Ata Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 9 March 2015 End date: 10 March 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 26

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Te Ata Rest Home provides rest home level care for up to 29 residents. On the day of audit, there were 26 residents.

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

The general manager, clinical nurse manager and rest home manager (registered nurse) are appropriately qualified and experienced for the roles they undertake. There are quality systems and processes being implemented to a very high standard which cover all aspects of service provision and are understood by staff.

An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to delivery care. Feedback from residents and family/whanau members was very positive about the care and services provided.

There are three areas for improvement related to open disclosure, documentation of medical exemptions for monthly reviews where the resident has been assessed as stable and medication management processes.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Some standards applicable to this service partially attained and of low risk.

Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions with residents. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents are treated with respect and received services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

There were no residents who identified as Maori residing at the service at the time of audit. There are no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written consents are obtained from the residents' enduring power of attorney (EPOA) or appointed guardians, as required. Processes are in place for advance care planning and, as medically indicated, resuscitation directives are recorded.

The organisation provides services that reflect current accepted good practice, as demonstrated in the guidelines for care of the aged person. There is regular in-service education and staff access external education that is focused on aged care and best practice.

The management and staff communicate effectively with residents and their family/whanau and provide an environment conducive to good communication. Documentation of communication and information to the family following any incident is not always evident and this needs to be improved.

The service has a documented complaints management system which is implemented. There were no outstanding complaints at the time of audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		All standards applicable to this service fully attained with some standards exceeded.
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The organisation's values, goals and mission statement have been identified in the business plan. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents' needs.

The quality and risk system and processes are undertaken effectively to provide safe service delivery and are a particular strength of the organisation. Te Ata Rest Home implements corrective action planning to manage any areas of concern or deficits found. Quality management reviews include internal audit process, complaints management, resident and family/whānau satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff, residents and family/whānau, as appropriate.

The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. This allowed residents' needs to be met in an effective, efficient and timely manner, as confirmed during resident and family/whānau interviews and in the 2014 satisfaction survey results.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and met legislative requirements.

Resident information is uniquely identifiable, accurately recorded, current, confidential, and accessible by staff when required. Residents' records were noted to be securely stored and there was no information of a private nature publicly displayed.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The entry criteria for the Te Ata Rest Home is clearly documented and communicated to the potential resident, family/whanau and referring agencies. If entry to the service was to be declined, a record is maintained and the potential resident and/or their family/whānau referred to a more appropriate service.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. Residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. The processes for nursing assessment, planning, provision, evaluation, review, and exit is provided within timeframes that safely meets the needs of the residents and contractual requirements. There is a shortfall identified in relation to providing documented evidence in medical records for when a patient is exempt from monthly reviews as they have been assessed as being stable and are reviewed three monthly.

The care plans describe the required support and/or intervention to achieve the desired outcomes. The provision of services and interventions is consistent with, and contributes to, meeting the residents' needs. Where progress is different from expected, the service responds by initiating changes to the care plan or with the use of short term care plans.

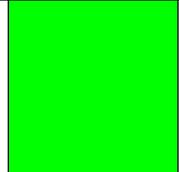
Resident support for access or referral to other health and/or disability service providers is appropriately facilitated. Documentation reviewed identified, documented, and minimised risks associated with each resident's transition, exit, discharge or transfer.

The service provides a planned activities programme to develop and maintain skills and interests that are meaningful to the resident.

Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage. The service is implementing a new system for medicine management. There is an area requiring improvement to ensure that these systems are completed and embedded into practice to meet legislation and best practice guidelines.

The menu has been reviewed by a dietitian as suitable for the older person living in long term care. The residents reported satisfaction with the food services.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented emergency management response processes which were understood and implemented by the service providers. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness and the service has an approved fire evacuation plan.

An internal restructure of the bedroom areas has increased the bed numbers from 28 to 29 and equipment and resources are adequate for the extended number of residents. No external footprint has been changed. The facilities meet residents' needs and provide furnishings and equipment that is regularly maintained.

There is adequate toilet, bathing and hand washing facilities. Designated lounge and dining areas meet residents' relaxation, activity and dining needs.

The facility heating is gas operated and ventilated to all areas. Opening doors and windows creates a good air flow to keep the facility cool when required. The outdoor areas provide suitable furnishings and shade for residents' use.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service maintains a restraint free environment. There was no recorded or sighted restraint or enabler use.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Te Ata Rest Home provides a managed environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined, with the infection control co-ordinator reporting directly to the management team, which includes the managing director.

There is a clearly defined infection prevention and control programme for which external advice and support is sought. An infection control coordinator (RN) leads the infection control committee and all staff are responsible for the implementation of the programme.

Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training, documented questionnaires and in topical sessions. Residents and family/whanau are supported with infection control information as appropriate. This was easily identified in relation to a recent infection control outbreak of gastroenteritis.

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

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	41	0	2	1	0	0
Criteria	4	86	0	2	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was displayed throughout the facility. New residents and families are provided with copies of the Code as part of the admission process. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The residents' files reviewed had consent forms signed by the resident or by the enduring power of attorney (EPOA). The caregivers demonstrated their ability to provide information that residents required in order for the residents to be actively involved in their care and decision-making. The files contained copies of any advance care planning and the resident's wishes for end of life care. Staff acknowledged the resident's right to make choices based on information presented to them.
Standard 1.1.11: Advocacy And Support Service providers recognise and	FA	Family/whānau reported that they were provided with information regarding access to advocacy services. Family/whānau were encouraged to involve themselves as advocates. Contact details for the Nationwide Health and Disability Advocacy Service was listed in the client information booklet, with the brochure available at the entrances to the service. Education is conducted as part of the in-service

facilitate the right of consumers to advocacy/support persons of their choice.		education programme.
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	There are no set visiting hours and family/whānau are encouraged to visit at any time. Family/whanau report there are no restrictions to visiting hours. Residents were supported and encouraged to access community services with visitors or as part of the planned activities programme.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Complaints management is implemented to meet policy requirements. As confirmed during management, resident and family/whanau interviews, complaints management was explained during the admission process. Residents confirm that the management's open door policy makes it easy to discuss concerns at any time. There have been no complaints since the previous audit as confirmed in the complaints register sighted. Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur. Complaints are a standing agenda item for both management and staff meetings as confirmed by meeting minutes sighted.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The family/whanau and residents report that the Code was explained to them on admission and was part of the admission pack. Nationwide Health and Disability Advocacy Service information was part of the admission pack with brochures available. The service receives input from the local advocate.
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.	FA	Family/whanau reported that their relatives were treated in a manner that shows regard to the resident's dignity, privacy and independence. The residents' files indicate that residents receive services that are responsive to their needs, values and beliefs. The family/whanau and residents reported high satisfaction with the way that the service meets the needs of the residents. No concerns from residents and family/whanau were expressed, they reported that residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

<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	<p>There were no residents who identified as Maori at the time of audit. The clinical manager reported that there are no barriers to Maori accessing the service. The service has had Maori residents in the past and have Maori residents who access the day support programmes. The caregivers interviewed demonstrated good understanding of services that are commensurate with the needs of the Maori resident and the importance of whanau.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The residents' files demonstrated consultation with families on the resident's individual values and beliefs. The family/whanau reported they were consulted with the assessment and care plan development. The caregivers interviewed demonstrated good knowledge on respecting each resident's culture, values and beliefs. The cultural needs of a resident who is from a different culture, had their specific needs recorded.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff files reviewed had job descriptions and employment agreements that had clear guidelines regarding professional boundaries. The family/whanau residents reported they are happy with the care provided. The families expressed no concerns with breaches in professional boundaries and all reported high satisfaction with the caring, calming and patient manner of the staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice was observed, promoting and encouraging good practice. Examples included policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with the local mental health services and palliative care services. The DHB care guidelines for aged care are utilised. The gerontological nurse specialist, district nurses and palliative nurses visit residents as required providing a consultation service.</p> <p>There is regular in-service education and staff access external education that is focused on aged care and best practice. The caregivers reported that they were 'very satisfied' with the relevance of the education provided. The family/whanau and residents expressed high satisfaction with the care delivered. They report that the service is 'well known in the community for providing loving quality care'.</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>The service promotes an environment that optimises communication through the use of interpreter services as required. Staff education has been provided related to appropriate communication methods. The service has not required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed.</p> <p>Documenting of opening disclosure following incidents/accidents is not always evident.</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>Strategic planning covers all aspects of service delivery. The purpose, values, scope, direction and goals of the organisation are documented and reviewed annually as part of the business planning process.</p> <p>The managing director (owner) works in the business on a daily basis and is an experienced manager. He is supported by a clinical nurse manager and three registered nurses who all hold current practising certificates. The before mentioned staff, along with the office administrator and community care coordinator make up the management team. All members attend education appropriate to the role they undertake. Job descriptions identify management members' experience, education, authority, accountability and responsibility for the provision of services.</p> <p>A formalised monthly management meeting is held to review strategic planning processes to ensure they are meeting resident and community needs.</p> <p>Interviews with residents and family/whanau confirmed that their needs were met by the service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The business plan outlined how the day to day operation of the service is managed and identified the reporting lines for staff to ensure the provision of services were offered to meet residents' needs.</p> <p>During a temporary absence of any member of the management team succession planning ensures all roles are fully performed to maintain service delivery. Service satisfaction was reported during resident and family/whanau interviews and by the results sighted for the 2014 resident and family/whanau satisfaction survey.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>CI</p>	<p>The service has a documented health and safety programme implemented which includes managing hazards, reporting and investing accidents, planning for emergencies, health and safety education to ensure staff, visitors and contractors meet the standards. The service undertakes systematic audits and results are used to improve services where indicated. Incident and accident reporting occurs in all</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>areas and is overseen by the clinical nurse manager and managing director.</p> <p>Having fully attained quality and risk management systems, the service has gained a continuous improvement rating as they are able to demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings and improvements to service provision which enhances resident safety and/or satisfaction. The organisation had a documented continuous quality plan which identified risks and shows the strategies in place to manage risks. All quality and risk issues are discussed monthly at staff and management meetings as confirmed during interviews and in meeting minutes sighted. The evaluation process measures the outcome of each corrective action put in place. The key components of service delivery (complaints, incidents and accidents, health and safety, hazards, restraint and infection control) are explicitly linked to the quality management system and outcomes documented identify how each outcome is measured on a monthly basis against required outcomes.</p> <p>All policies and procedures sighted were up to date, reflected current good practice and met legislative requirements. The document control system ensures that obsolete documents are removed from use.</p> <p>Regular audits are undertaken and corrective action planning put in place to manage any deficits found. Staff confirmed that all follow up actions were discussed during handover and at regular staff meetings. Staff education related to occupational safety and health practices are maintained to assist staff to provide safe service delivery.</p> <p>Staff, resident and family/whanau interviews confirmed any concerns they have were addressed by management.</p> <p>Actual and potential risks are identified and documented in the hazard register. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The incident and accident forms used by the service identify who has been notified. It is not always identified on the form if family/whanau have been informed. Refer to comments in criterion 1.1.9.1. However, family/whanau members interviewed stated they are kept fully informed.</p> <p>Adverse, unplanned or untoward events sighted for 2014-2015 identify that actions taken are documented and the collective data is graphed monthly and measured against previously collated data so that any areas of deficit can be followed up using the corrective action process. Management interviewed confirmed that information is used as an opportunity to improve services where indicated.</p> <p>The need to make essential notification to statutory and/or regulatory bodies is fully understood and complied with as identified in the reporting process undertaken related to infection outbreak</p>

		<p>management.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. The incident and accident register sighted shows monthly reviews by the management team which were clearly documented.</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>	FA	<p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. This includes police vetting of staff upon employment. Position descriptions, sighted for all roles, described staff responsibilities and best practice standards. The staff have completed an orientation programme with specific competencies for their roles which are repeated annually as confirmed during staff files reviewed.</p> <p>Policy is implemented to ensure staff undertake training and education related to their appointed roles. For example clinical staff undertake education related to a recognised age care education programme and kitchen staff attend food safety training. Staff education occurs as part of the staff meeting days and covers all aspects of service provision to meet contractual requirements. This was confirmed in the education records sighted for 2014-2015.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted for four registered nurses (RNs), 12 general practitioners (GPs) and one pharmacist. RN practising certificates are displayed on the notice board for all residents and visitors to see.</p> <p>Resident and family/whanau members interviewed, along with the 2014 satisfaction survey results, identified that residents' needs are met by the service. No negative comments were voiced during interviews on the days 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>	FA	<p>Policy identifies staffing hours are rostered to meet residents' needs and to comply with contractual requirements. Additional staff rostered to meet residents' needs was observed on the days of audit. Required staffing levels and skill mix is clearly documented.</p> <p>A review of six weeks of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents interviewed stated all their needs have been met in a timely manner.</p> <p>There is a registered nurse on duty Monday to Friday for eight hours and on call 24 hours, seven days</p>

		a week. The diversional therapist and laundry staff work Monday to Friday and there are dedicated kitchen and cleaning staff seven days a week.
<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>	FA	The residents' files identified that information is managed in an accurate and timely manner. Health information was kept in secure areas in the nurses' station and these was not accessible or observable to the public. There was no private information on display in the facility. The archived records are securely stored onsite. The resident's progress notes recorded the name and designation of the staff member.
<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	The care facility provides rest home level care. The residents were required to have an assessment for rest home level of care prior to admission. The entry criteria, assessment and entry process was clearly documented and communicated to the potential resident and family/whānau.
<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>	FA	When admission is required to the acute care hospital, the service utilises the DHBs transfer form/envelope. The referral process documents any risks associated with each resident's transition, exit, discharge, or transfer. This includes expressed concerns of the resident and family/whānau and a copy of any advance directives. With the transfer form/envelope, the clinical manager reported that the service also provided a copy of any other relevant information, such as medication chart. A file of a resident reviewed with a recent admission to the acute care hospital evidenced that the transfer to and from the hospital was effectively managed. The clinical manager also reported they have recently transferred a resident to another care facility and the interRAI access for the resident was provided to the new facility as part of the transfer process.
<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</p>	PA Moderate	The service was transitioning to the robotic sachet pre-packed medication system at the time of audit. This included transitioning the controlled drugs and the pre-packed sachets. The pre-packed medicines and the signing sheets are compared against the medicine prescription. Most medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident. The service did have some bulk supply/impress stock of antibiotics. Not all medicines were signed as given and the controlled drug management system was not able to be evidenced to ensure best practice guidelines are being met.

<p>guidelines.</p>		<p>The medicines and medicine trolley were securely stored. The medicine fridge was monitored for temperature daily, with the sighted temperatures within medicine storage guidelines.</p> <p>The resident's GP conducts a medicine reconciliation on admission to the service and when the resident has any changes made by other specialists. The medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. All of the medicine charts were reviewed by the GP in the past three months. The service does not use standing orders, all 'PRN' (as required) medicines are prescribed on the individual resident's medicine chart.</p> <p>Medication competencies were sighted for all staff who assist with the medicine management, this included the RNs and some senior caregivers.</p> <p>The RN reported that there were no residents who self-administer medicines. The service has policies, procedures and self-administration guidelines to assess if a resident was competent to administer their own medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The menu was last reviewed in January 2015 by a dietitian and was considered suitable for the older person living in long term care. The service has a four week rotational menu with seasonal variations. Residents were routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. The residents reported satisfaction with the meals and fluids provided.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complies with current legislation and guidelines. Fridge and freezer recordings were undertaken daily and met requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. Evidence was seen of all kitchen staff having completed safe food handling certificates and ongoing in house education.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The clinical manager reported that they have not declined entry to any potential residents who have an appropriate needs assessment. The clinical manager reports that if entry to the service was to be declined, the referrer, potential resident and where appropriate their family/whānau would be informed of the reason for this and of other options or alternative services. The services enquiry form has a section to record reason for declining an admission if this was to occur.</p> <p>The admission agreement contains information on the termination of the agreement. The admission agreement documented if the resident's needs changed and the service can no longer provide a safe level of care to meet the needs of the resident, they would be reassessed for the appropriate level of care. The clinical manager reported residents requiring hospital level of care or dementia level of care</p>

		have been transferred to a facility that provides these services.
<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>The service has commenced interRAI training and conducting the interRAI assessments for the residents. A mix of the electronic records and the service's own assessment tools were in use at the time of audit. The service is using additional assessment tools for skin integrity/pressure area risk, falls risk, continence assessment and nutritional assessment. The care plans sighted reflected the assessed needs of the residents. The assessment processes sighted in the residents' files covered the resident's physical, psycho-social, cultural and spiritual needs. Where required, the service accesses specialist assessment services through the DHB, such as wound assessment or mental health assessments.</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>Residents' files evidenced individualised care plans that reflected the resident's individual needs. The triggers from the interRAI assessment process and other assessment and nursing clinical judgment are incorporated into the care planning. The residents' files and care plans demonstrated service integration. Files had one main folder that contained the medical information, nursing assessment, care plan, routine observations, therapies, family correspondence and specialist consultations. There are additional files for short term care planning and diversional/activities planning. These are linked through the handover reporting and the caregivers sign the communication book to indicate that they have read the short term care plans.</p> <p>The residents and family/whanau reported that the staff have excellent knowledge and care skills. The GP interviewed expressed satisfaction with the care provided.</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>	FA	<p>The provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs and desired outcomes. The care plans reviewed were individualised and personalised to meet the needs of the residents. The care was flexible and focused on promoting quality of life for the residents. All residents and family/whanau reported satisfaction with the care and service delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	FA	<p>Each resident's file sighted has an activities/diversional therapy assessment. The activities coordinator reported that from these assessments they are able to develop either group or individual activities to meet the interests of the residents. Feedback on the activities programme is also sought through the residents' meetings. The activities coordinator reported that they gauge the response of residents</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>during activities and modified the programme related to the response and interest. The activities programme covers physical, social, recreational and emotional needs of the residents. The service has links with other community organisations, churches, local schools and child care centres. The residents and family/whanau reported satisfaction with the activities provided.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluations are documented, resident-focused, indicate the degree of achievement or response to the support and/or interventions, and progress towards meeting the desired outcomes. The health assessment form is used as the evaluation tool. The comments on the health assessment tool indicates the resident's response to interventions. The care plans are then updated to reflect any changes in interventions. All care plans sighted were developed, reviewed and evaluated at least six monthly.</p> <p>Where progress was different from expected, the service responded by initiating changes to the care plan or by use of short term care plans for temporary changes. Short term care plans were sighted in the files reviewed. When short term care plans are implemented, the staff sign the communication book that they have read these. The changes in care or temporary needs of residents are included at shift handover.</p> <p>The residents and family/whanau interviewed reported satisfaction with the care provided at the service.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) 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>	<p>FA</p>	<p>Residents are able to maintain their own GP if available. The RN or the GP arranged for any referral to specialist medical services when it was necessary. The resident's files had appropriate referrals to other health and diagnostic services. Referrals were sighted for consultations with mental health services, general medicine and surgical services. The GP reported that appropriate referrals to other health and disability services were well managed at the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm</p>	<p>FA</p>	<p>Policies and procedure located in the infection control manual described the disposal processes undertaken to protect visitors, residents and service providers from harm as the result of exposure to waste, infectious or hazardous substances are implemented by the service.</p> <p>All chemicals were seen to be securely stored and clearly labelled. Personal protective</p>

<p>as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>equipment/clothing (PPE) sighted included disposable gloves and aprons and goggles. Staff interviewed confirmed they can access PPE at any time. Staff were observed wearing disposal gloves and aprons as required. A certificate of compliance was sighted from a regional service stating the facility is compliant with waste disposal.</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>FA</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The current warrant of fitness was issued on the 17 June 2014.</p> <p>Maintenance was undertaken by both internal maintenance and external contractors as required. Electrical safety testing occurs annually or when any new appliances are introduced to the facility. This is undertaken by a registered electrician. All electrical equipment sighted had an approved testing tag.</p> <p>Clinical equipment, such as oxygen regulators, sit on weigh scales and sphygmomanometers, were tested and calibrated by an approved provider at least annually or when required. This is confirmed in the asset register sighted.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. Regular environmental audits sighted identify that the service actively worked to maintain a safe environment for staff and residents.</p> <p>The service identifies planned annual maintenance in their business plan which is reviewed on a monthly basis at the management meetings. Progress is documented and signed off by the managing director when completed.</p> <p>There are easily accessed, level surface, shaded outdoor areas for residents.</p> <p>Interviews with residents and family/whanau members confirmed the environment was suitable to meet their needs.</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</p>	<p>FA</p>	<p>There are adequate toilet/shower facilities for residents with separate staff and visitor facilities. One area with three toilets is due for maintenance and the maintenance plan identified this is scheduled for refurbishment within the next 12 months. The managing director stated plans to undertake this work are underway and costing have been completed.</p> <p>Hot water temperatures are monitored and documentation identified that they remained within safe levels.</p>

requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. They are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings. There are seven bedrooms which are shared and they have appropriate curtaining to ensure visual privacy.</p> <p>Resident and family/whānau member interviews confirmed they were happy with their bedrooms and that privacy is never an issue.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. There are two lounge areas, one has a dining area which is separated by furnishings and flooring and the other is a defined lounge. There is also a separate dining area. Areas contained comfortable furnishings to meet residents' needs. Residents and family/whanau voiced their satisfaction with the environment. Activities are undertaken in both lounge areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Policies and procedures identified how the provision of safe and hygienic cleaning and laundry services were to be provided. This included the safe storage of chemicals used. As observed, PPE was readily available and used appropriately during cleaning processes. Chemicals were clearly labelled and safety data sheets available.</p> <p>Documentation sighted for laundry and kitchen equipment identified that the provider of chemicals used monitored the chemical usage, washing machine operations and dishwasher cycles for effectiveness.</p> <p>Staff maintained the cleaning schedule sighted. A quality improvement project involved the introduction of antibacterial wipes on a daily basis. Staff confirmed when interviewed that they had been fully informed and involved in the project.</p> <p>Laundry chemicals are now measured using a premeasure product. The laundry staff confirmed this is monitored by the provider and has been working well. The laundry is locked when not in use. A quality initiative involved ongoing education for laundry staff to ensure they do not overload the washing machines. This is well documented and monitored by the infection control committee member who works in the laundry and has been discussed and reported on monthly at management and staff meetings.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, communication, exit doors and stair wells. Fire equipment is checked annually by an approved provider.</p> <p>Emergency supplies and equipment include food and water should they be required. There are first aid supplies which are kept up to date. The emergency evacuation plan and general principles of evacuation were clearly documented in the fire service approved fire evacuation plan. There have been no changes in the building footprint since the previous audit. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting which lasts for up to eight hours, and gas BBQs for cooking.</p> <p>Emergency education and training for staff includes six monthly trial evacuations. No follow actions were noted for the last two evacuations in documentation sighted. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service. Staff have completed an annual emergency questionnaire as confirmed in staff education reviews sighted.</p> <p>Staff are required to ensure doors and windows are securely closed at night. There is adequate outdoor lighting. Staff and residents interviewed confirmed they feel safe at all times.</p> <p>Call bells are located in all residents' bedrooms. Resident and family/whanau interviewed confirmed call bells were answered in an acceptable timeframe.</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>Resident areas have at least one opening window to provide natural light and for ventilation. Heating throughout the facility is gas and centrally ventilated throughout the building. The facility was warm and well aired on the days of audit. Resident and family/whanau interviewed stated the facility is kept at a suitable temperature throughout the year.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service</p>	<p>FA</p>	<p>Te Ata Rest Home provides an environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. The programme aims to establish, maintain and monitor procedures covering infection control practices. The programme includes actions required by staff, residents and visitors when exposed to infectious diseases. Understanding of infection control exercises was confirmed by staff, resident and</p>

<p>providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>family/whanau members interviewed.</p> <p>All staff are required to take responsibility for infection reporting. The lines of accountability for infection control matters are defined with the infection control coordinator (RN) taking responsibility for implementing the programme, and all data reported to management and staff. This is verified during interviews with staff. The infection control coordinator is responsible for ensuring appropriate resources are available for the effective delivery of the programme and to coordinate the annual review.</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>As described in policy the infection control coordinator (ICC) is a RN. A signed position description for the role is identified in the staff member's personnel file. The ICC has completed a recognised infection control education programme.</p> <p>Staff interviewed, including the infection control coordinator, confirm these are sufficient resources to implement the programme. The infection control committee consists of the ICC, staff from laundry and cleaning services and a second RN.</p> <p>Implementation of the infection control programme was evident through review of data collection records, action plans, completed audits and competency assessments. The service had an infectious outbreak of gastroenteritis in August 2014 which was managed according to the IC programme in place. Corrective actions following the outbreak include updating laundry and cleaning policies and processes to include the effectiveness of the cleaning regime, and resident and family/whanau education related to standard precautions.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>Policies and procedure reflect current accepted good practice. They cover all aspects of infection control management, including the correct use of personal protective clothing/equipment. Cleaning and laundry procedures are located within the infection control information.</p> <p>The infection control programme annual review includes compliance with policies and procedures. These policies are appropriate to the services offered by the facility.</p> <p>All staff interviewed verbalised their knowledge and understanding of standard precautions and stated they undertake actions according the IC policies and procedures as required.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff receive orientation and ongoing education in IC and prevention as verified by staff training records and confirmed by staff interviewed. Staff are required to complete an annual worksheet related to infection control practices and to perform witnessed hand washing techniques. Staff have access to on-line infection control education and access to specialist services if required.</p> <p>Family/whanau interviewed confirmed they received information and education regarding a recent outbreak and that the use of sanitising gel has been fully explained to them.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>In line with Te Ata Rest Home's policy, procedures and IC programme, monthly surveillance data is collected for each infection reported. Information is graphed, reviewed and evaluated by the infection control committee and management and then presented at monthly staff meetings. This information identifies trends or possible causative factors and corrective actions are put in place if required.</p> <p>A gastroenteritis outbreak in August 2014 was handled promptly and in line with best practice. Appropriate authorities and family/whanau members were notified. A full review of the process resulted in several improvements being made by the service. The improvements are clearly documented and reviewed monthly.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service maintains a restraint free environment. There was no recorded restraint or enabler use. If enablers are to be used, policy identified that these will be voluntary and the least restrictive option. The staff demonstrated knowledge of restraint minimisation and confirmed there is no restraint used. The staff receive ongoing training on the management of challenging behaviours and de-escalation techniques to avoid restraint use.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	The incidents/accidents forms reviewed from 2014 to 2015 evidence that approximately half of the incident forms do not document that the family/whanāu have been informed. The family/whanau did confirm they are kept informed of the resident's status, including any events adversely affecting the resident. The principles of open disclosure could not be evidenced in these files. The staff interviewed reported that they do contact the family, though this was not apparent in the documentation reviewed. On review of the incident forms that did not document that family had been informed, there was also no recorded evidence in the resident's progress notes that the family had been informed.	It is not always evidenced that family are informed of incidents.	Ensure that family notification is consistently documented to maintain open disclosure principles. 180 days
Criterion 1.3.12.1 A medicines management system is implemented to	PA Moderate	In seven of the 15 medication charts reviewed there was at least one time where it was not recorded if the medication was given. It was not clear if the medication was given and not signed for or if the medication	Seven of the 15 medication charts reviewed have at	Ensure there is documented evidence that

<p>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>had been withheld. The new medication signing sheets have been implemented in the past two weeks. This is considered a low risk to the residents as it relates to the documentation of the medications given only.</p> <p>The service has commenced a new system for the management of controlled drugs on the days of audit. As the system is being implemented on the day of audit, it was not able to be evidenced that the controlled drug register, the storage of controlled drugs and administration recording process complies with the required legislation and guidelines.</p> <p>The service had a bulk supply or impress stock of antibiotics. A corrective action is made to ensure the service complies with the medicine guidelines for rest home level of care.</p>	<p>least one time when it was not recorded if the medication was given.</p> <p>The new system for management of controlled drugs was being implemented at the time of audit and therefore compliance with how the controlled drug management systems could not be verified.</p> <p>The rest home has a bulk supply of medicines that are not individually labelled for the resident.</p>	<p>all medicines are signed as given, or the reason for withholding the medication recorded.</p> <p>Ensure there is documented evidence that the management of controlled drugs complies with legislation and aged care guidelines.</p> <p>Ensure the bulk supply of medicine is managed according to legislative and aged care requirements.</p> <p>90 days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely</p>	<p>PA Low</p>	<p>In four of the six residents files, the resident was regularly reviewed by the GP three monthly. It was not clearly identified or recorded in the resident's file that they have been assessed as stable and suitable for the three monthly medical reviews. In the remaining file one resident had been seen monthly by the GP and the other had medical and specialist medical reviews recorded two weekly. The contract the service has with the DHB requires the exemption for the three monthly</p>	<p>Four of the six residents' files do not record the exemption for the three monthly medical reviews.</p>	<p>Ensure documentation is provided that the exemption for the three monthly</p>

meet the needs of the consumer.		reviews be recorded in the resident's medical record. The DHB contract requirement at D16.5.e.i.1 is partially met.		medical reviews are recorded. 180 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	CI	The key components of service delivery, complaints, incidents and accidents, health and safety, hazards, restraint and infection control are linked to the quality and management system.	The key components of service delivery are standing agenda items for management and staff meetings. All data is collected monthly, collated, trended, reviewed by management and corrective actions put in place if any deficits are noted. This information is shared with staff, residents and family/whanau as appropriate. Each key component has a set quality goal which is regularly reviewed and evaluation is documented to indicate how improvements have impacted on resident satisfaction and/or safety.
Criterion 1.2.3.6 Quality	CI	Quality improvement data collected has been used to inform quality goals which	Examples of improvements made to the service relate to actions taken covering staff training, including trialling new equipment to lower resident fall rates, and newly introduced cleaning products to help prevent infection. When a quality goal is reached the service developed a new

<p>improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>		<p>are reviewed monthly. Resident and family/whanau are kept informed where appropriate.</p> <p>Information is gathered related to family/resident annual survey results, resident meeting queries, audit processes and quality data collected for incidents and accidents, infection control, health and safety and complaints. The service is restraint free.</p>	<p>goal to maintain the quality improvement process.</p> <p>Goals sighted relate to all aspects of service delivery areas such as kitchen, cleaning and resident/clinical areas. There was evidence that residents and family/whanau were informed where appropriate such as during a recent gastroenteritis outbreak. This included making them aware of the need to use sanitising gel when entering and leaving the facility, being able to identify symptoms and making them aware they could contact a member of management at any time if they had any concerns. All learnings from the outbreak have been used to improve service delivery related to cleaning processes which involved rewriting policy and procedure and the introduction of new chemical processes. Items are reviewed monthly (or sooner if there are any concerns) and progress or outcomes are evaluated by management to ensure the desired goals are reached. This information was located on quality improvement forms sighted. The process is overseen by the managing director. Staff, resident and family/whanau interviewed confirmed they feel included and well informed about any new processes put in place.</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>CI</p>	<p>The service have used a documented process to measure the achievement of each quality goal they have in place. Quality goals are documented for all quality improvements made so the process can be regularly reviewed and managed to achieve a positive outcome.</p>	<p>The review process implemented to measure quality improvements involved monthly management review meetings where the service undertakes a self-review process which includes an internal audit process. Audit data was used as the baseline data for comparison during the improvement process. Corrective actions are written for each improvement required. The evaluation process includes measuring the outcome and the degree to which each action has improved service delivery safety or resident satisfaction. If the desired goal is not being reached the whole quality process is re-commenced with varying corrective actions.</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>CI</p>	<p>Corrective actions reviewed for 2014-2015 show that all actions are followed up accordingly. Information is gathered from audits, quality statistical data, complaints, resident meetings, hazard management and satisfaction survey results used to improve services where required.</p>	<p>Corrective action processes inform the quality goals at organisational level. These decisions are made by all of the management team on a monthly basis for non-urgent corrections. Urgent corrective actions are identified by senior staff and approved by the managing director. All corrective actions are informed to staff at handover, in memo form and at staff meetings. As staff implement the actions, their input into the evaluation of corrective measures taken is documented and discussed at meetings. If a corrective action appears not to be work then actions are changed so the service can reach their required quality goals.</p>
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End of the report.