

Wyndham and Districts Community Rest Home Incorporated - Wyndham and District Community Rest Home

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

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

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

The specifics of this audit included:

Legal entity:	Wyndham and Districts Community Rest Home Incorporated
Premises audited:	Wyndham and Districts Community Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 August 2015 End date: 6 August 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:	19

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Wyndham and Districts Community Rest Home provides care for up to 23 residents. On the day of the audit there were 19 residents residing at the facility. This certification audit was conducted against the relevant Health and Disability Standards and the service contract with the district health board.

The audit process included review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

There are areas identified as requiring improvement around: communication with family following adverse events; complaints management system; completion of corrective action plans; human resources management systems; staff education; staff orientation; analysis and trending of quality improvement data; resident observations following adverse events; assessment of a resident requiring hospital level of care; review of policies; hot water monitoring; registered nurse entries in progress notes; completion of short term care plans; review of the infection control programme and medication management systems.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk</p>
---	--	--

Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for residents. The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding residents' rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
--	--	---

Wyndham and Districts Community Rest Home Incorporated is the governing body and is responsible for the services provided at Wyndham and Districts Community Rest Home. Review of the facility's business plan, a mission statement, philosophy and quality and risk management plan were conducted.

The nurse manager, who is a registered nurse, is responsible for the overall management of the facility, including oversight of the clinical care provided. The nurse manager is supported by a registered nurse and registered nurse cover is provided five days a week.

There is evidence that quality improvement data has been collected and collated and that this information is reported to staff. There is an internal audit programme in place and internal audits have been completed. Risks are identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

There are policies and procedures on human resources management and the validation of current annual practising certificates for health professionals who required them to practice has occurred. In-service education is provided for staff on a monthly basis. Staff individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mix. The minimum number of staff on duty at any one time is one care giver on night shift. The registered nurses share the after-hours on call. Care staff interviewed reported there are adequate staff available and that they are able to get through their work.

Resident information is entered into a register in an accurate and timely manner.

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>
---	--	---

The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. The registered nurses are responsible for the assessment, care plan development and evaluation of care in consultation with the resident/family/whanau. The interRAI assessment tool has been used for all residents' care planning. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. There is an integrated team approach to care with input from allied health professionals.

Planned activities are appropriate to the resident's assessed needs and abilities and residents expressed satisfaction with the activities programme.

Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by the general practitioners.

All food is cooked on site and kitchen staff have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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

A current building warrant of fitness is in place. The maintenance programme includes medical equipment and electrical checks. The environment is appropriate to the needs of the residents. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

All laundry is washed on site. Cleaning and laundry systems are monitored to evaluate the effectiveness of these services. Protective equipment and clothing is provided and used by staff.

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

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.
---	--	--

Wyndham rest home has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there was one resident using restraint and no enablers.

Infection prevention and control

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
--	--	--

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	41	0	3	6	0	0
Criteria	0	85	0	11	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the in-service education programme. Interviews with staff confirm their understanding of the Code.</p> <p>Staff were observed demonstrating knowledge and understanding of the Code in their everyday practice by: maintaining residents' privacy, giving residents' choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.</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>	FA	<p>Informed consent and advanced directives were recorded as evidenced in the resident files reviewed. Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they are able to decline or withdraw their consent. There were six admission agreements sighted as signed. Discussion with family identify the service actively involves them in decisions that affect their relative's lives.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services is provided to residents and families and available at the facility. Staff training on the role of advocacy services was included in training on The Code of Health and Disability Consumers' Rights, last provided in August 2014.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they stated that they have been informed about advocacy services. The residents' files include information on resident's family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families interviewed confirmed they can visit at any time and are always made to feel welcome. Residents are encouraged to be involved in community activities and to maintain family and friends networks.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>Complaints /compliments forms are available at the facility. A complaints register is in place and does not record any complaints for 2015. Complaints for 2014 were reviewed and indicated there were two complaints referred to the police and the Ministry of Health. The nurse manager stated that there had been no complaints since their appointment to the position and no complaints that they are aware of with the Health and Disability Commission, ACC and DHB since the previous audit. Residents and family members interviewed stated that they would feel comfortable complaining.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The nurse manager (NM) or the registered nurse (RN) discuss the Code with residents and their family on admission. Residents and family interviews confirm their rights are being upheld by the service.</p> <p>Information regarding the Health and Disability Advocacy Service is</p>

		displayed at the facility. Residents and family members were able to describe their rights and advocacy services.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service's policies and procedures are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Resident support needs are assessed including details of residents' beliefs and values. Interventions to support these are recorded and evaluated. Residents' files reviewed identified that cultural and /or spiritual values and individual preferences are identified. Church services are held at the facility.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour.</p> <p>The residents' own personal belongings are used to decorate their rooms. Discussions of private nature are held in the resident's room and there are areas in the facility which are used for private discussions.</p> <p>Staff were observed to: knock on bedroom doors prior to entering; keeping doors shut when cares were being given and did not hold personal discussions in public areas. Residents and families interviewed confirm the residents' privacy is respected.</p> <p>There is a policy on the prevention and detection of abuse and neglect. Education / training on abuse and neglect has not been provided for staff (refer to criterion 1.2.7.5).</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is Maori health plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged. Links to local kaumatua and Maori services are through the district health board.</p> <p>There was one Maori resident living at the facility during the audit. Cultural needs were identified in the resident's care plan sighted. There are staff who identify as Maori.</p> <p>Staff are aware of the importance of whanau in the delivery of care for the</p>

		Maori resident.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service records each resident's personal needs from the time of admission. This is achieved with the resident, family and/or their representative.</p> <p>There is a culture of choice with the resident determining when cares occur and choices in activities they attend. Residents and family are involved in the assessment and the care planning processes.</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 policies, procedures and staff code of conduct record good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Staff training includes discussion of the staff code of conduct. Job descriptions include responsibilities of the position. Staff orientation and employee agreements include standards of conduct. Interviews with staff confirm their understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There is specialised training in place for registered nursing staff through Southland District Health Board (SDHB) and Southland hospice (refer to criterion 1.2.7.5). Residents and families interviewed expressed a high level of satisfaction with the care delivered. The general practitioner reported a high standard of care provided at the service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>There is a documented open disclosure policy. The practise of open disclosure is communicated to staff at orientation and at staff in-service education, last conducted in January 2015. Interpreter services are available from the district health board. There were no residents requiring interpreting services at the facility on audit days.</p>
<p>Standard 1.2.1: Governance</p>	FA	<p>Wyndham and Districts Community Rest Home Incorporated is the</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>governing body and is responsible for the services provided at Wyndham rest home. A business plan and a quality and risk management plan were reviewed and include goals. The service philosophy is in an understandable form and is available to staff, residents and their family / representative or other services involved in referring residents to the service.</p> <p>The nurse manager (NM), who is a registered nurse, is responsible for the overall management of the facility, including oversight of the clinical care provided. The NM is supported by one part time registered nurse (RN), a part time enrolled nurse (EN) and on call registered nurses who share the on call with the NM and the part time RN. The personal files and annual practising certificates for the NM, the registered nurses (RNs) and the EN were reviewed. The NM provides monthly reports to the board, however these could not be reviewed as they were with the financial auditor at time of audit.</p> <p>The NM was appointed to their current position in March 2015. The previous nurse manager resigned from their position in January 2015. There was a period of nine weeks when there was no permanent nurse manager at the facility. During this time the administrator managed the general running of the rest home and the permanent part time RN was appointed as an interim manager to manage the clinical oversight. The nurse manager's past professional experience has been in the DHB and private surgical hospital and community.</p> <p>Wyndham rest home is currently certified to provide 23 rest home level beds. On the first day of audit there were 19 residents at the facility. One resident is assessed as requiring hospital level care and Ministry of Health dispensation was sighted for this resident. There is another resident who has been deemed as requiring hospital level of care (refer to criterion 1.2.4.2). The service provider has contracts with the district health board (DHB) to provide aged related residential care (rest home) and residential respite services and hospital services for one resident.</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</p>	<p>FA</p>	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the nurse manager be absent. The registered nurse fills in for the NM. Interview of the NM confirmed their</p>

<p>the provision of timely, appropriate, and safe services to consumers.</p>		<p>responsibility and authority for this role and the RN responsibilities during the NM absence.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>A business plan and quality and risk management plan are used to guide the quality programme and include goals and objectives. There is an internal audit programme in place and completed internal audits for 2014 and 2015 were reviewed. Risks management plan is in place and includes health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures.</p> <p>Monthly staff meetings are held along with monthly residents' meetings. Meeting minutes were reviewed and these are available for review by staff. Meeting minutes reviewed provide evidence of reporting / feedback on completion of internal audits and various clinical indicators. Staff interviewed reported they are kept informed of quality and risk management issues. Adverse events are documented on accident/incident forms and copies of these are retained in the residents' files.</p>
<p>Standard 1.2.4: Adverse Event Reporting 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 Moderate</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures.</p> <p>Registered nurses (RN) are advised of all adverse events. Interviews with staff confirmed that the on-call RN visits the facility and assesses the resident following an adverse event when there is no RN on duty. There is a RN on site five days a week (Monday to Friday). All accident and incident forms are reviewed by the nurse manager (NM) when they next come on duty.</p> <p>Residents' files reviewed did not consistently record the evidence of communication with family on the accident/incident form, in resident progress notes, and in whanau/family communication sheets (refer to</p>

		<p>criterion 1.1.9.1).</p> <p>Corrective action plans to address areas requiring improvement are not consistently documented on accident/incident forms (refer to criterion 1.2.3.8).</p> <p>The appointment of the interim manager and the new nurse manager appointment have been communicated to HealthCERT.</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 Moderate</p>	<p>Human resource management processes are documented and available. Copies of annual practising certificates were reviewed for all staff that require them to practice and are current.</p> <p>The nurse manager is responsible for the in-service education programme. There is evidence indicating in-service education is provided for staff at the monthly staff meetings. The education planners for 2014 and 2015 were reviewed. Staff attendance records for education session were reviewed and provide evidence ongoing education is provided. Staff are supported to complete education via external education providers.</p> <p>An appraisal schedule is in place and current staff appraisals were sighted on the staff files reviewed. Care staff confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p> <p>An orientation/induction programme was available and all new staff are required to complete this prior to their commencement of care to residents. The nurse manager advised that staff are orientated for two shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to six weeks to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed orientation, including competency assessments (as appropriate).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	<p>FA</p>	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided five days a week (Monday to Friday) during</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>the morning shifts. On call after hours registered nurse support and advice is shared between the nurse manager and the registered nurses. The minimum amount of staff on duty is on night shift and consists of one caregiver.</p> <p>Care staff interviewed reported there is adequate staff available and that they are able to get through their work. All care staff have current first aid certificates and there is at least one staff member with a current first aid certificate on each shift (refer to criterion 1.4.7.1). Residents and family interviewed reported staff provide them with adequate care.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Resident information is entered in an accurate and timely manner into a register (hard copy) on the day of admission. Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed. Resident files reviewed provide evidence that an entry into the residents' clinical record includes the time of entry, the date and entries are dated (refer to criterion 1.3.8.2).</p> <p>Residents' information is stored in staff areas and is held securely and not on public display. Clinical notes are current and accessible to all clinical staff. The resident's NHI number, name, date of birth and GP are used as the unique identifier.</p> <p>Clinical staff interviewed including the nurse manager, the RN, caregivers and the activities co-ordinator confirmed they know how to maintain confidentiality of resident information. Historical records are held securely on site and are accessible.</p>
<p>Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The entry and assessment processes are recorded. The facility information pack is available for residents and their family and contained all relevant information.</p> <p>The residents' admission agreements evidenced resident and /or family and facility representative sign off. The needs assessments were completed for all residents. One resident who was observed to be receiving a higher level of care, has had a recent interRAI assessment completed (link #1.2.4.3). Residents and family confirmed on interview</p>

		that the admission process was completed by staff in a timely manner. All relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There was appropriate communication between families and other providers in the residents' files that demonstrated transition, exit, discharge or transfer plans were communicated, when required. Transition, exit, discharge, or transfer form / letters / plan were located in residents' files, where this was required.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	<p>Medication storage and prescribing documentation meets guidelines and current legislative requirements. On interview, the RN reported that prescribed medications were delivered to the facility and checked on entry. The medication area, including controlled drug storage evidenced an appropriate and secure medicine dispensing system. The controlled drug register was maintained and evidenced six monthly physical stock takes. Regular weekly controlled drug checks have not been conducted. The medication fridge temperatures were conducted and recorded. Regular medications are appropriately recorded when given. Transcribing of medication orders was evident in the sample of medication charts reviewed.</p> <p>All caregivers and the registered nurse have current completed medication competencies. The nurse manager and casual registered nurses have not completed a medication competency. The medication round was observed, however, correct procedure was not followed by the staff member administering medications. Administration records were maintained, as were specimen signatures. Staff education in medicine management has been conducted.</p> <p>One resident who self-administers medicines had the relevant assessment and reviews completed. Staff check on every shift that medications have been taken and the medication was stored securely.</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 food service policies and procedures are appropriate to the service setting. There is a five week seasonal menu that was reviewed by a nutritionist in May 2015. The service employs two cooks who both have relevant food safety qualifications. The food service is managed in line with recognised food safety programmes. Food is stored appropriately in the kitchen and pantry and is labelled and dated. The kitchen was observed to be clean and tidy. Staff conduct kitchen cleaning and sign off when this is completed. Decanted foods were dated.</p> <p>On interviews, the cook and care staff confirmed they were aware of the residents' individual dietary needs. There were copies of the residents' dietary profiles in the kitchen. The kitchen staff were informed if resident's dietary requirements change, confirmed at interview with the cook.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided. The fridge, freezer and hot food dish temperatures were recorded.</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 scope of the service provided is identified and communicated to all concerned. A process to inform residents and family, in an appropriate manner, of the reasons why the service had been declined would be implemented, if required. Advised by the nurse manager and registered nurse that residents would be declined entry if not within the scope of the service or if a bed was not available. The resident would be referred back to the referring service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The residents' needs, outcomes and goals were identified via the assessment process and recorded. The facility has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery. The part time registered nurse has completed the interRAI training and all residents have had the interRAI assessment completed either on admission or at care plan review. Long term care plans are</p>

		<p>based on the interRAI assessment.</p> <p>The residents' files evidenced residents' discharge/transfer information from DHB (where required) were available. The facility had appropriate resources and equipment, confirmed at staff interviews. In interview, the RN and nurse manager confirmed that assessments were conducted in a safe and appropriate setting including visits from the doctor. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</p>
<p>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 residents' care plans were individualised, integrated and up to date. The care plan interventions reflected the assessments and the level of care required. Short term care plans that have been developed when required were signed off by the RN when problems were resolved (link #1.3.8.3). In interviews, staff reported they received adequate information for continuity of residents' care. The residents had input into their care planning and review, confirmed at resident and family interviews. Regular GP care was implemented, sighted in current GP progress reports and confirmed at GP interview.</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 residents' care plans evidenced interventions based on assessed needs, desired outcomes or goals of the residents. The sample of care plans reviewed are based on the interRAI assessments conducted. Interviews with the nurse manager, registered nurse, caregivers and residents evidence resident and family input.</p> <p>Dressing supplies are available and adequately stocked for use. Wound assessment, wound treatment, frequency of dressings and evaluations for one resident with a skin tear was documented and linked with a short term care plan. Pressure area prevention cares are documented in the care plan for one resident. There were no residents with pressure injuries. The RN interviewed advised that they have access to external to wound specialist as required. Specialist continence advice was available as needed and this could be described. The GP documentation and records were current. In interviews, residents and family confirmed their and their relatives' current care and treatments met their needs. Progress notes and</p>

		observations charts were maintained. Staff confirmed they were familiar with the current interventions of the residents they were allocated.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities coordinator provides an activities programme over five days each week. Weekend activities are spontaneous and supervised by weekend care givers. Activities planned for the day were displayed on a board. An activity plan is developed for each individual resident based on assessed needs. The activity plans were reviewed at the same time as the care plans in resident files sampled. Residents were encouraged to join in activities that were appropriate and meaningful and to participate in community activities. The service has a van that is used for weekly outings. Residents were observed participating in activities on the days of the audit. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Moderate	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations were comprehensive and included a reassessment of the interRAI assessment tool. A new care plan is then developed as evidenced in four resident files reviewed. Two residents do not yet require care plan evaluations. Initial care plans sighted for the sample of residents had been evaluated by the RN within three weeks of admission. Time frames in relation to care planning evaluations were documented. In interviews, residents and family confirmed their participation in care plan evaluations.</p> <p>Care staff document progress notes on every shift. Registered nurse entries in progress notes were noted to be infrequent (link #1.3.8.2). When resident's progress was different than expected, the RN contacted the GP, as required, however, these events have not been recorded in progress notes. Short term care plans were not utilised for all short term care issues. The family were notified of any changes in resident's condition, confirmed at family interviews, however this is not consistently recorded (link #1.1.9.1).</p> <p>There was recorded evidence of additional input from professionals, specialists or multi-disciplinary sources, if this was required.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services. This included referrals to DHB specialists. Family communication sheets confirmed family involvement.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place. Material safety data sheets are available and accessible for staff. Interview with a cleaner confirmed there is safe storage and safe use of chemicals. Sluice facilities are provided for the disposal of waste. There is evidence that chemicals are correctly labelled and securely stored.</p> <p>Protective clothing and equipment that is appropriate to the recognized risks associated with waste or hazardous substance being handled is available. Protective clothing and equipment was observed to be used by staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The facility's maintenance is conducted following any reactive maintenance issues, following environmental audit findings and according to the preventative maintenance plan. Maintenance at the facility is completed by persons from the board and by external contractors. The nurse manager and the board chairperson advised that external contractors are used for plumbing, electrical and other specialist areas.</p> <p>Medical equipment calibration/performance is performed annually by an external contractor. There is safe storage of medical equipment. Current electrical safety tags are located on electrical items. Care staff interviewed confirm they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.</p> <p>A current building warrant of fitness is posted at the entrance to the facility (expiry date 19 June 2016). There have been no building modifications since the last audit.</p> <p>Corridors are wide enough for residents to pass each other safely. Safety</p>

		rails are secure and are appropriately located. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs. The external areas (patios and gardens) are maintained and are appropriate to the resident groups and setting. There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	All bedrooms have hand basins and some have shared ensuites. There are an adequate number of communal showers, toilets and wash hand basins for residents. Toilets and showers are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Communal toilets are located close to communal areas. The communal toilets and shared ensuites have a system that indicates if it is vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.
<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	There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed spoke positively about their rooms. Residents requiring the use of a hoist in their rooms have sufficient space for the hoist and staff. Rooms are personalized with residents' furnishings, photos and other personal adornments. There is one double bedroom, however this was not used on audit days. There is sufficient room at the facility for storage of wheelchairs and motorised scooters.
<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	The service has a lounge and dining area and second lounge /day room. All communal areas are easily accessed by residents, visitors and staff. Residents are able to access areas for privacy, if required. The furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The laundry has a clean and dirty flow and there are documented laundry processes for staff to follow. All laundry is completed on site and managed by care staff. The night caregiver irons and folds washing. Cleaning service is conducted by cleaning staff seven days a week. Cleaning products are purchased from a recognised provider. Interview with the cleaner confirmed the cleaning processes are followed and cleaning schedules are signed off when completed. Cleaning and laundry is monitored through the internal audit process. Chemicals and cleaning cupboards were locked.</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>Sighted an evacuation plan that was approved by the New Zealand Fire Service in 2002. An evacuation policy on emergency and security situations is in place. Fire drills take place six-monthly, with the last drill conducted in May 2015. Staff confirmed their awareness of emergency procedures.</p> <p>There is always one staff member on duty with a first aid certificate. This was confirmed through review of staff rosters and confirmed by the nurse manager.</p> <p>There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. Emergency lighting is in place and this is tested alongside the fire systems. The facility has a generator.</p> <p>An electronic call bell system is in place and there are call bells in all residents' rooms, residents' toilets, and communal areas.</p> <p>The doors are locked in the evenings and can only be opened from the inside. Systems are in place to ensure the facility is secure and safe for the residents and staff.</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>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.</p> <p>Family and residents interviewed confirmed the facilities are maintained at an appropriate temperature and the service was warm on the day of the</p>

		audit noting that the outdoor temperature was cold.
<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>	PA Low	Wyndham rest home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The nurse manager is the designated infection control nurse with support from the registered nurse and staff (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation and annually. The infection control programme has not been reviewed.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The nurse manager (infection control coordinator) at Wyndham rest home has experience and qualifications in infection prevention and control. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<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>	FA	There are infection control policy and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by an external provider in 2013.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control</p>	FA	The infection control policy states that the facility is committed to the on-going education of staff and residents. Formal infection control education

<p>to all service providers, support staff, and consumers.</p>		<p>for staff has occurred. The nurse manager has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</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>Infection surveillance is an integral part of the infection control programme and is described in Wyndham rest home's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. No outbreaks have been reported.</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 has documented systems in place to ensure the use of restraint is actively minimized. The facility has one resident who has been assessed for restraint in the form of bedrails. No other residents have restraint or enablers. All necessary documentation has been completed in relation to the restraint. Staff interviews and staff records evidence guidance has been given on restraint minimisation, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint use audit has been conducted and restraint has been discussed as part of staff meetings. The nurse manager is the designated restraint coordinator.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on</p>	<p>FA</p>	<p>The nurse manager is the restraint coordinator. Advised by the restraint coordinator that assessment and approval process for a restraint intervention includes the restraint coordinator, resident/or representative and medical practitioner.</p>

restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	The service has completed a comprehensive assessment and consent for the one hospital resident who requires restraint as evidenced in the file reviewed and on interview with the restraint coordinator. These were undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for the restraint. The one restraint file reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the file reviewed. The service had a restraint and enablers register which was up dated each month.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	The service has documented evaluation of restraint every three months. In the restraint file reviewed, evaluations had been completed with the family/whanau, restraint co-ordinator and medical practitioner. Restraint practices were reviewed on a formal basis every month by the restraint co-ordinator at staff meetings. Evaluation timeframes were determined by risk levels. The evaluations had been completed with the family/whanau, restraint co-ordinator and medical practitioner
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews were completed monthly or sooner if a need is identified. Reviews were completed by the restraint co-ordinator. Restraint use is reviewed as part of the staff meeting.

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 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	The complaints policy and procedure, complaints flow chart and the complaints form do not comply with the Right 10 of the Code. This was communicated to the facility via the document review prior to the on-site audit, however no policy review was conducted.	The complaints processes are not in line with Right 10 of the Code.	<p>Provide evidence the complaints processes comply with the Right 10 of the Code.</p> <p>90 days</p>
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	Records of one complaint was sighted in the complaints folder, however this complaint is not recorded in the complaints register. One complaint in the complaints register does not evidence that a letter of acknowledgement was sent to the complainant and there is no record of the complainant being	The complaints register does not include all complaints lodged, dates and actions taken.	<p>Provide evidence the complaints register is up to-date and includes all complaints lodged, dates and actions taken.</p> <p>180 days</p>

		informed of advocacy support services.		
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>There are policies and procedures on adverse events and open disclosure. Staff are aware of their responsibility to notify family/enduring power of attorney of any accidents/incidents that occur. Review of accident/incident forms evidenced that information of the adverse event is not consistently communicated to the family and the resident. Ten adverse event forms were reviewed. One of ten adverse event forms was not fully completed to include if family notification occurred and the resident's progress notes and the family communication form did not record this had occurred. There was no recorded evidence that the family were notified of the adverse events in five of ten adverse events forms reviewed.</p>	<p>There is inconsistency in recording the notification of adverse events to family and residents.</p>	<p>Provide evidence adverse events are communicated to family and residents to ensure full and frank open disclosure is practised.</p> <p>90 days</p>
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular</p>	PA Low	<p>Systems are in place for reviewing and updating policies and procedures. Policies and procedures have been obtained from external sources, however there have been no updates provided for these policies by the external contractor since the introduction of the policies to the facility. The policies have</p>	<p>Current policies do not reference interRAI assessment processes and the individual policies evidence limited alterations/ changes.</p>	<p>Provide evidence of inclusion of the interRAI processes in the relevant policies and complete comprehensive review of all policies.</p> <p>180 days</p>

intervals as defined by policy.		<p>been reviewed in house. The indexes of the policy manuals evidence current review sign off, however the individual policies evidence limited alterations/changes have been instigated in the last 12 years.</p> <p>The assessment and care planning policy does not reference the InterRAI assessment tool and processes relating to interRAI.</p>		
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Moderate	<p>There is documented evidence quality improvement data is collected and collated, however the data is inconsistently analysed and evaluated to identify trends. The monthly staff meeting minutes reviewed provide evidence that information is reported to staff.</p> <p>Resident /relative satisfaction audit was conducted in May 2015. The results of the satisfaction survey have been collated, however there is limited analysis of the data recorded and there has been no communication with the residents, staff and family regarding the results of the survey.</p>	Quality improvement data is not being comprehensively analysed and evaluated to identify trends and communicated to all concerned.	<p>Provide documented evidence that quality improvement data is being comprehensively analysed and evaluated to identify trends and this is communicated to all concerned.</p> <p>180 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet</p>	PA Low	There is an internal audit schedule and audits are conducted according to this schedule. Areas identified as requiring improvement from	Adverse event forms, internal audits and meeting minutes do not consistently evidence that corrective action plans are	Provide evidence that corrective action plans are developed and implemented where areas are identified as requiring

<p>the specified Standard or requirements is developed and implemented.</p>		<p>completed audits are recorded on the audit forms and transferred onto the audit review form. The audit review form records the recommendations, corrective actions required, name of person completing the corrective actions and date this is completed. There is inconsistency in completing the corrective action part of this form and completion of the corrective action plans.</p> <p>Meeting minutes do not provide evidence of reporting and monitoring of corrective action plans. Adverse event forms do not consistently record corrective action plans where required.</p>	<p>developed, implemented, monitored and evaluated to address shortfalls identified.</p>	<p>improvement.</p> <p>180 days</p>
<p>Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	<p>PA Moderate</p>	<p>There is one resident requiring hospital level of care at the facility. This resident has been assessed at this level of care and a dispensation has been obtained from HealthCERT for this resident to reside in the facility.</p> <p>Interviews with staff and GP, observations and review of another resident's file confirmed this resident is cared for at the facility at hospital level of care. This resident's care needs have increased to require two persons' care and full assistance with activities of daily living. Interview with the GP confirmed this resident has required this level of care since April 2015. The resident</p>	<p>A resident requiring hospital level of care has not been assessed at this level and this information has not been communicated to HealthCERT to obtain dispensation for this resident to remain at the rest home.</p>	<p>Provide evidence of a current assessment of the resident requiring hospital level of care and communicate this information to HealthCERT to obtain dispensation for this resident to remain at the facility.</p> <p>30 days</p>

		<p>has not been assessed as requiring hospital level of care and HealthCERT have not been notified by the facility this has occurred.</p> <p>Staff interviews confirmed being able to manage to care for both the residents (one that has been assessed as requiring hospital level of care and the second resident that awaits assessment).</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 Moderate</p>	<p>Three of ten adverse event forms relating to residents' possible head injury as a result of a fall, did not record assessments and observations were conducted in timely manner.</p>	<p>Staff do not consistently complete neurological observations when there is a risk of head injury following adverse events.</p>	<p>Provide evidence timely observations are conducted and recorded where there is a risk of head injury following adverse event.</p> <p>60 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>The skills and knowledge required for each position within the service is documented in job descriptions. Staff files reviewed evidenced: no job description for one RN; no job description for the infection coordinator, restraint coordinator and privacy officer; no police vetting in five of the six files reviewed and no reference checking in staff files.</p>	<p>Staff files evidence human resource management practices are inconsistently completed.</p>	<p>Provide evidence the human resource processes are followed.</p> <p>180 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive</p>	<p>PA Low</p>	<p>Orientation is provided for all staff who commence work at the facility.</p>	<p>The nurse manager has not completed an orientation</p>	<p>Provide evidence the orientation programme is role specific and</p>

<p>an orientation/induction programme that covers the essential components of the service provided.</p>		<p>There is a generic orientation book that all staff use as the orientation tool. The nurse manager's file evidenced they have completed an orientation programme that is a generic programme for all staff. Interview with the nurse manager and the board chairperson confirmed orientation for the nurse manager has not been fully completed due to the past nurse manager's resignation prior to the appointment of the current nurse manager.</p>	<p>programme specific to their role.</p>	<p>the nurse manager has completed orientation to their role.</p> <p>90 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>There is evidence of monthly staff education topics being provided at the facility, however not all required education has occurred, such as abuse and neglect. Staff education/training attendance records reviewed evidence that not all staff are attending in service education on regular basis. The nurse manager has not conducted relevant education relating to management of an aged care facility. A number of care givers have not completed the required education relating to the care of older people as stated in the ARC contract.</p> <p>Sighted Careerforce implementation plan to meet the SDHB ARC agreement specifications. Also sighted correspondence with the Careerforce workplace advisor supporting the training action plan for staff to complete the New</p>	<p>There is evidence that: the required staff education is not provided; not all staff are attending in-service education on regular basis; not all care staff have completed the required education relating to the care of older people and the nurse manager has not completed training in management and the health and personal care of older people.</p>	<p>Provide evidence that: all required staff education is provided; all staff are attending in-service education on regular basis; all care staff have completed the required education relating to the care of older people and the nurse manager has completed training in management and the health and personal care of older people.</p> <p>180 days</p>

		Zealand Qualifications Authority approved aged care education modules. Interview with the nurse manager confirmed this programme is to commence at the facility.		
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Medicine charts evidenced residents' photo identification, medicine charts were legible, as required (PRN) medication was identified for individual residents and correctly prescribed, three monthly medicine reviews were conducted and discontinued medicines were dated and signed by the GPs. The residents' medicine charts recorded all medications a resident was taking. A staff member was observed administering medications, however, did not follow the correct procedure. Controlled drugs were securely stored and the register aligns with the medications on hand. Six monthly stock checks are conducted by the pharmacist. Regular weekly controlled drug checks have not been conducted. Transcribing of medication orders was evident in the sample of medication charts reviewed.</p>	<p>i) Weekly checks of the controlled drugs have not been undertaken; ii) transcribing of medication orders was evident in the 12 medication files reviewed – on the front page for each residents medication file and on individual signing sheets for as required and non-packed medications; iii) the staff member observed administering medications did not follow the correct procedure. The medications were signed for prior to administration.</p>	<p>i) Provide evidence that weekly controlled drug checks are undertaken; ii) cease transcribing medication orders; iii) ensure that all staff follow the correct procedure for administering medications</p> <p>30 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the</p>	<p>PA Low</p>	<p>The registered nurse and senior caregivers have received training in medications in August 2014 and again in February 2015. Annual</p>	<p>The nurse manager and casual registered nurses who provide on-call cover have not completed a medication competency at</p>	<p>Provide evidence that all staff who are responsible for medication administration have a current medication</p>

function for each stage they manage.		competencies have been completed for warfarin, insulin and blood sugar monitoring, and medication administration. The nurse manager has conducted competency assessment for staff but has not completed a medication competency.	Wyndham rest home.	competency which is relevant to the scope of practice at Wyndham rest home. 60 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Moderate	All aspects of the assessment and care planning process have been conducted within the required time frames as evidenced in the sample of files reviewed. Care staff document in progress notes on every shift. The registered nurses write in progress notes on an infrequent basis. Care plan evaluations are conducted six monthly and interRAI reassessments are completed in the sample of resident files reviewed. Activities care plan reviews were conducted in the sample of files reviewed. Short term care plans were evident in resident files however, these lacked sufficient detail to guide staff. Examples of short term care plans were for infections, skin tears, wound management, behaviours, pain, and medication changes.	i) On review of progress notes, it was noted that there are infrequent registered nursing entries in to progress notes, and a lack of evidence that registered nurses have documented the reviews of caregiver entries in to residents progress notes; ii) short term care plans reviewed do not provide sufficient detailed interventions to guide staff in caring for residents with changes in health condition.	i) Provide evidence that there is regular registered nurse review of residents progress; ii) ensure that short term care plans are sufficiently detailed to guide care staff in implementing the care requirements for residents. 60 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with	PA Low	Sighted hot water temperature monitoring conducted in June 2015 that evidenced all temperatures	Hot water temperatures are not regularly monitored.	Provide evidence the hot water temperatures are monitored regularly to ensure hot water is

legislation.		were within the safe hot water temperature range. There is no recorded evidence of any other times in 2014 and 2015 that hot water monitoring was done.		provided within the recommended temperature range. 60 days
Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.	PA Low	The infection control programme includes policies and procedures, surveillance of infections and education and training for staff. Monthly surveillance data is provided to staff. A review of the infection control programme has not been conducted.	The infection control programme has not been reviewed annually.	Provided evidence that the infection control programme has been reviewed at least annually. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.