

# Glenlaurel Care Limited - Lexham Gardens Rest Home

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Glenlaurel Care Limited
<b>Premises audited:</b>	Lexham Gardens Rest Home
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 14 September 2015    End date: 15 September 2015
<b>Proposed changes to current services (if any):</b>	Proposed change of provider.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	39

# Executive summary of the audit

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## Introduction

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

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

## General overview of the audit

Lexham Gardens Rest Home is a privately owned 46 bed facility for residents requiring rest home and hospital level care. This provisional audit was undertaken to establish the prospective owner's preparedness to provide a health and disability service and the level of conformity with the required standards.

The 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/whānau, management, staff, the general practitioner, the current provider's representatives and the prospective owner.

The existing services have nine areas identified for improvement in relation to: complaints management; sharing of quality and risk information and corrective action planning; staff education planning and records; staff annual appraisals; and archiving of clinical

record. Improvements are also required related to multidisciplinary care meetings, minor internal building repairs, hot water temperatures in the shower areas, and emergency management processes.

The prospective provider has aged care management experience and has no immediate plans to change any systems or services.

## **Consumer rights**

Staff interviewed demonstrated good knowledge and practice of respecting residents` rights in their day to day interactions. Staff receive education on the Health and Disability Commissioner`s (HDC) Code of Health and Disability Services Consumers` Right (the Code). Advocacy services are readily available and contact numbers are accessible. Interpreter services are available if required.

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

Written informed consents are obtained from the resident, family/whānau, enduring power of attorney (EPOA) as required. Signed consent forms were sighted in all residents` records reviewed.

Open disclosure and effective communication is encouraged by staff and the contracted general practitioner (GP) for all incidents and accidents or any untoward events.

Linkages with family and the community are encouraged and maintained.

The service has a documented complaints management system which is not being implemented; this needs to be addressed. The facility confirms there are no outstanding complaints at the time of audit.

## Organisational management

The service has a business and quality plan in place. The organisation's mission statement, goals and philosophy as currently documented will be continued by the prospective owner to ensure residents' needs continue to be met. The prospective owner has a documented business plan showing the new organisational structure, identifying the new governance and management structure. There is a detailed transition plan which covers staff management during the transition. The existing policies and procedures will be maintained along with the quality and risk management systems and staffing levels.

The current documented quality and risk systems and processes support safe service delivery. The quality management systems include identification of hazards, staff education and training, an internal audit process, complaints management, and data gathering and reporting of incidents/accidents and infections. Several areas have been identified for improvement relate to documentation which does not show how staff are informed of quality data information, incomplete documentation related to quality findings, and the internal audit processes which is not up to date.

The prospective owner is aware of the findings as she was present on the two days of audit. She intends to maintain the existing systems and will work towards meeting all required improvements. The current owner will be available for any assistance for up to six months.

Policies and procedures are managed by a contracted agency and the prospective provider will continue to use this service.

The service implements the documented staffing levels and skill mix which will be maintained by the prospective owner. The day to day operation of the facility is undertaken by staff who are appropriately experienced in aged care. Resident and family/whānau interviewed confirmed that all their needs are met.

Human resources management processes require improvement related to annual staff evaluations being kept up to date, and documented evidence related to staff ongoing education. As the prospective owner is experienced in aged care management, she has a good understanding of human resources requirements. Existing staff will be given the opportunity for continued employment. The prospective owner will work in the facility management role and the current facility manager is aware of this.

All current resident information is collected in an integrated record folder and stored in a safe place. Records are current and up to date. There is an area requiring improvement related to the archived records system and retrieval of records as required.

## **Continuum of service delivery**

Pre-admission information clearly and accurately identifies the services offered. The service agreements are signed by the resident, family and/or enduring power of attorney (EPOA) on admission to the service.

Services are provided by suitably qualified and skilled staff to meet the needs of residents. All new admissions have a comprehensive interRAI assessment completed by a registered nurse. Timeframes for the development of the long term resident centred care plan are met. When there are changes in the resident`s needs, a short term care plan is implemented to reflect this. The registered nurses complete the care plan interRAI evaluations six monthly on all aspects of the care plan. There is an area requiring improvement related to the absence of multidisciplinary reviews being performed or evidenced in the records sampled.

The GP reviews all residents on admission to the service and then monthly for the hospital level residents and three monthly for the rest home residents. Reviews occur more frequently if required. Referrals to other health and disability services is planned and coordinated, based on the individual needs of the resident.

The service has a planned activities programme to meet the social and recreational needs of the residents. Residents are encouraged to maintain links with family/whānau and the community.

A safe medication system was observed at the time of the audit. The staff responsible for medication management have completed annual competencies.

The residents` nutritional requirements are effectively met by the service with preferences and special diets catered for and food available 24 hours a day. The service employs experienced staff who prepare the meals from a four week rotating menu plan, which has been approved by a registered dietitian.

## **Safe and appropriate environment**

Services are provided in a clean, safe, secure environment that is appropriate to the level of care provided. There are appropriate amenities to meet residents' needs and to facilitate independence. Residents, visitors and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery. Large items of laundry are cleaned by a contracted off-site provider. There are adequate toilets, showers and bathing facilities. Maintaining safe water temperatures is an area requiring improvement.

Documentation identifies that all processes are maintained to meet the requirements of the building warrant of fitness.

Planned and reactive maintenance is documented. The cupboard areas in the sluice room and the laundry require maintenance. Systems are in place for essential, emergency and security services, including a disaster and emergency management plan. No emergency evacuation drill has occurred since September 2014 and this is an area identified for improvement.

All residents have access to outdoor areas.

The prospective provider has no plans to change any service and as the present owner is maintaining ownership of the building there is currently no plan in place to change the facility footprint.

## **Restraint minimisation and safe practice**

Policies and procedures in place reflect current good practice and meet legislative and Health and Disability Services Standard requirements. Staff have a full understanding of what is required should restraint be used. The service operates a restraint free environment which the prospective owner hopes to maintain.

## Infection prevention and control

The infection prevention and control management system is appropriate for the complexity of the service. The programme is implemented and reduces risk of infections to residents, staff, family/whānau and visitors. The policies and procedures reflect current accepted good practice. Relevant education is provided for staff and when appropriate the residents. The infection control coordinator completes a monthly surveillance programme, where infections data is collated, analysed and trended with previous data. Where any trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at the staff monthly meetings. An infection prevention and control service provides education and advice as needed.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	37	0	7	1	0	0
<b>Criteria</b>	0	84	0	8	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). The service policy states the Code is displayed and available to all residents and monitored to ensure the rights of residents are respected. New residents and family are given a copy of the Code on admission. The Code is displayed on the wall in full view of residents, caregivers and visitors to the facility.</p> <p>Staff receive training on the Code at commencement of employment as part of the orientation process. The Code is available in English, Māori and other languages for residents with English as a second language.</p> <p>The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>	<p>FA</p>	<p>A detailed informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to assist them to make</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>informed choices and to give informed consent. The staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Residents interviewed confirmed they have been made aware of and understand the informed consent processes and that appropriate information has been provided.</p> <p>A multi-purpose informed consent form is utilised by the service provider and a copy was retained in each resident's record reviewed. Forms were signed and dated appropriately. The admission agreements were signed and dated by the resident and/or a representative.</p> <p>The GP interviewed understands the obligations and legislative requirement to ensure competency of residents as required for advance directives and reviews are undertaken six monthly. Reviews of health status are documented on the appropriate form available and retained in the individual resident's record.</p> <p>Registered nurses interviewed reported they received orientation/induction in the principles and practice of informed consent as part of the Code of Rights and could evidence an understanding of the Code.</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>The advocacy policy documented ensures that all residents receiving care within this organisation have appropriate access to independent advice and support, including access to a cultural and spiritual advocate whenever required.</p> <p>Family interviewed reported they were provided with information regarding access to advocacy services. Contact details of the Nationwide Health and Disability Advocacy Service is listed in the resident information provided. The contact numbers are also documented on the reverse of the Health and Disability Services Consumers' Rights brochure. Relevant education for staff is conducted as part of the in-service programme, as confirmed by the staff interviewed</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</p>	<p>FA</p>	<p>There are no set visiting hours and family are encouraged to visit. This is confirmed by family and staff interviewed.</p> <p>Residents are supported and encouraged to access community</p>

<p>their community.</p>		<p>services with visitors or as part of the planned activities programme. Evidence was seen of this in the activity programme records and reported by residents interviewed.</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 Low</p>	<p>The complaints policy identifies how Right 10 of the Code will be met. Complaints management is explained as part of the admission process and is included in the information given to new residents. Complaints management is included in new staff orientation and included in ongoing education. This is confirmed during staff interviews.</p> <p>Family/whānau confirmed during interview their understanding of the complaints procedure. Residents interviewed stated they would and have complained to the RN if any issues arise.</p> <p>The complaints register contains no documentation since July 2013. The facility manager confirmed that any minor issues are addressed immediately but this process is poorly documented. One family/whānau member and one resident verbalised how minor complaints they made had been fully addressed. The facility manager stated there are no open complaints at the time of audit.</p> <p>The prospective owner understands the consumer's right to make a complaint.</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 standard operations identifies that a copy of the Code and information about the Nationwide Health And Disability Health and Disability Advocacy Service is provided to the resident and family on admission and that the admitting registered nurse is to go through the Code with the resident/family on admission.</p> <p>The family members that were available for interview reported that the Code was explained to them on admission and this was part of the admission pack provided. Interviews with residents who were able to provide insight into their care, expressed that they were treated with respect and were happy at the facility.</p> <p>An interpreter service is available when required. The prospective provider interviewed has an excellent understanding of the consumer rights.</p>

		Evidence is seen of the Code of rights being displayed throughout the facility. Staff demonstrated respect to all residents. Staff displayed knowledge of the Code during interviews.
<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>A dignity and privacy policy requires the visual privacy and personal space of residents to be respected and observed at all times and that staff will facilitate the use of private space for interaction with visitors and significant others as required. The wishes of residents are acknowledged, sexuality and personal rights are upheld, independence maintained, maximised and encouraged.</p> <p>The family/whānau members interviewed reported that their relatives were treated in a manner that showed regard to the resident's dignity, privacy and independence.</p> <p>The residents' records reviewed indicated that residents received services that were responsive to their needs, values and beliefs of culture, religion and ethnicity.</p> <p>The families interviewed reported satisfaction with the way that the service meets the needs of their relatives. Church services are provided at the rest home weekly on a Friday and every second Tuesday.</p> <p>As observed on the day of the audit and confirmed with review of the individual resident's records randomly selected, residents receive services appropriately to meet their needs. No concerns in relation to abuse and neglect were reported from residents, the GP, family and/or staff interviewed. Comments made reflected a positive atmosphere from staff and family.</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>The Māori Health Plan and policies sighted acknowledge the organisation's responsibilities to Māori residents in accordance with the Treaty of Waitangi. The organisation is committed to identifying the needs of its residents and ensuring that staff are trained and capable of working appropriately with all residents in their care. The provision of culturally appropriate services and the identification and reduction of barriers are part of the organisation's documented Māori Health Plan objectives.</p> <p>The guidelines for provision of culturally safe services for Māori</p>

		<p>residents are available to guide staff and was reviewed in January 2015. Rooms are blessed as required. There are no known barriers that exist for Māori residents to access this service.</p> <p>There were no Māori residents or staff who identify as Māori at the time of the audit. The healthcare assistants interviewed demonstrated good understanding of services that would need to be provided for Māori residents to meet identified needs and the importance of whānau.</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 spiritual, religious and cultural policies and procedures provide information to guide staff on protocol. A cultural needs assessment tool is available to ensure the identified needs can be effectively met. The registered nurses ensure that any cultural needs are identified on admission and are communicated to the healthcare assistants who provide the majority of personal care to residents. Staff reported they received training in cultural awareness. Cultural needs were documented on the resident centred care plans reviewed.</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 have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. There are clear definitions of discrimination.</p> <p>The staff Code of conduct sighted has five key objectives in place to be upheld for residents. The family and residents interviewed reported they are happy with the care provided. The nurse manager and the registered nurses have all completed the professional boundaries workshop which is a requirement for the New Zealand Nursing Council.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The registered nurses promote and encourage best practice with staff. Evidence of this was demonstrated in interviews with the registered nurses and healthcare assistants. Policies and procedures are developed by a contracted quality consultant who ensures these are updated on a regular basis and are linked to evidence-based practice. The GP interviewed is pleased to have discussions with family if required and to visit residents as needed. The family and residents interviewed expressed satisfaction with the care delivered.</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>FA</p>	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. An interpreter service is available and accessible if required.</p> <p>Family/residents interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented in the family communication record, in the progress notes and through the incident accident system, as explained by the registered nurse. A record of incidents was recorded in the residents' records randomly selected and could be followed through effectively.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>On the day of audit 39 beds are occupied, nine hospital level care and 30 rest home level care. The service has a business plan which identifies the organisation's mission statement, vision and philosophy and shows the organisation's planning process to meet residents' needs. The prospective owner is aware that the direction and goals of the organisation need to be reviewed regularly. She has developed a business plan ongoing for 2015-2016 with added projections for a five year period.</p> <p>The quality programmes and procedures described in policy include, hazard management, staff training and education, data reporting of incidents/accidents, infections and internal audit. The proposed owner will use the quality programme data to identify trends and improve services.</p> <p>The prospective owner intends to work in the role of facility manager. She is experienced in this role and has worked in aged care in New Zealand for several years. Staff will be able to reapply for a role in the organisation which is similar or the same as the roles they already undertake. The current owner will be available for advice over a six month period following takeover.</p> <p>Interviews with residents and family/whānau confirmed that their needs were met by the service.</p>
<p>Standard 1.2.2: Service Management</p>	<p>FA</p>	<p>Currently during a temporary absence of the facility manager the clinical leader and the owner undertake specific parts of the role.</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>When the clinical leader is away the role is undertaken by another registered nurse. The prospective owner is aware of required staffing ratios and will ensure these are maintained. She will operate an open door policy so staff are supported through the transition process. This process is documented in the transition plan sighted.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The service has a business plan and quality and risk processes in place which covers all aspects of service delivery. The quality planning policy identifies generalised goals and objectives and the measure used to identify how the controls are effective or responsive to resident needs. This includes key components of service such as complaints management, infection control, health and safety and human resource management. Quality data collection and analysis occurs to identify areas of deficit. Senior staff confirm they understand the processes in place. Actions taken to improve services, such as to reduce resident falls and medication errors are documented but there are no set goals to evaluate the collected data against. Documented evidence that quality data information is shared with all staff could not be found.</p> <p>The internal audit system is one process used to measure achievement against the quality and risk management plan. However, the audit plan sighted is incomplete and audits have not been kept up to date.</p> <p>Policies and procedures are managed by an off-site company. All policies sighted were up to date and reflected evidence based practice.</p> <p>Actual and potential risks are identified and documented in the hazard register. A newly appointed health and safety representative actively maintains the register. She confirms that new hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p> <p>There were no negative comments from resident and family/whānau interviews. They confirmed services are provided in a manner which meets their needs.</p> <p>The prospective owner intends to work within the facility and will attend all staff meetings. She will continue with the existing policies</p>

		<p>and procedures which she is very familiar with. She has a good understanding of the quality processes described to measure achievements against the documented quality plan and will use a compliance checklist to monitor all processes. Her aim is for a seamless handover to occur between the current owner and herself. The prospective owner has undertaken appropriate ongoing education and has a developed support network within the aged care industry.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>	FA	<p>Policy is implemented related to adverse events. The facility manager fully understood the obligations in relation to essential notification reporting and knows which regulatory bodies must be notified as identified in policy. Staff interviewed stated they report and record all incidents and accidents on a specific form. Adverse event information is used to improve services. One example relates to the actions taken to reduce medication errors.</p> <p>Family/whānau are notified of any adverse, unplanned or untoward events at all times. This was identified on incident and accident forms sighted and in resident file reviews. Family/whānau interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives.</p> <p>The prospective owner is conversant with legislative and compliance issues which may impact on the service. At the time of audit there are no legislative known compliance issues concerning health and safety, employment or local body that could affect the service.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Human resources policies describe good employment practices that meet the requirements of legislation. Newly appointed staff are police vetted upon employment, referees are checked and job descriptions clearly described staff responsibilities. Staff complete an orientation/induction programme with specific competencies for their roles, such as medication management, as confirmed during staff file reviews. The prospective owner does not intend to change employment processes. Not all staff annual performance reviews are up to date.</p> <p>Current, staff education could not be verified during the audit. All education records are kept electronically and no one had access to these on the days of audit. Staff confirmed during interview that they</p>

		<p>are offered in-service education and senior staff stated they have attended off site educational sessions. This is supported by documentation sighted showing that the facility manager and the clinical leader were registered to attend the 2015 gerontology nursing conference in August.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.</p> <p>Resident and family/whānau members interviewed identified that residents' needs are met by the service. No negative comments were voiced during interviews on the day of audit.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service implements a documented process for ensuring staffing levels allow safe and efficient services to be delivered to residents to meet all their identified needs. Rosters sighted identify that staff are replaced for annual leave or sick leave. All shifts are covered by a staff member who holds a current first aid certificate.</p> <p>During staff interviews they verbalised that they have sufficient time and staff to complete their required duties.</p> <p>The prospective owner intends to maintain the current staffing levels. She can verbalise her understanding of the skill mix required for a hospital and rest home complex.</p> <p>Residents interviewed stated all their needs have been met in a timely manner.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>Information is entered into the interRAI system and a copy is maintained in the current resident's records selected randomly for review. The resident information board is out of sight of the public and records are stored in a locked cupboard in the nurses' office. The resident register is maintained and is current and up-to-date. Resident records sampled demonstrated that entries are legible and the writer of each entry signs and initials their signature, initials and designation. Records are integrated with information from all disciplines, external provider and medico-legal information.</p> <p>The locked room for storing archive records was accessed by the lead</p>

		auditor and the nurse manager. Records were found to be stored in boxes in no special order. No systems are in place to retrieve records easily if required.
<p><b>Standard 1.3.1: Entry To Services</b></p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The administrator has an admission/enquiry form that records the pre-admission information. There is a current resident's pack available for this care setting. There is adequate information about the service and the services provided along with the contact details of the service and the nurse manager.</p> <p>The resident agreement is based on the Aged Care Association agreement which is individualised to the service. The residents' records reviewed have signed and dated admission agreements. The admission agreement identifies any additional charges that are not covered by the service agreement and the relevant costs of each charge required. Incontinence products are only charged if the resident or family chooses a brand that is different to those provided by the facility.</p> <p>All residents at the facility have been pre-assessed prior to admission as requiring either rest home or hospital level care.</p>
<p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b></p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The clinical leader interviewed stated risks are identified prior to planned discharges. A transfer form is used and the 'yellow bag' system, a DHB requirement, is utilised. The staff ensure open disclosure between services and family/whānau related to all aspects of service delivery occurs. This includes residents for either discharge and/or transfer to another facility or to the DHB.</p> <p>If there are any specific requests or concerns that the resident or family want discussed, these are noted on the transfer form. The discharge form and care plan summary is provided and covers all personal cares or needs of the resident and any interventions required. Any known risks, alerts or concerns are highlighted. If a transfer occurs a copy of the medication record with any known allergies and/or sensitivities, the resident information page and/or any advance directives also accompany the resident, if they are transferred to hospital.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The policies are accessible to guide staff as required. The sighted policies meet the legislative and best practice guidelines. All medications are managed by registered nurses due to the nature of this service being rest home and hospital and all have completed annual competencies.</p> <p>Medicines for residents are received from the pharmacy in a pre-packed delivery system. On arrival to the facility the medications are checked by the registered nurse on duty. The medications are stored in the lockable medication trolley available and the medication room was sighted and is locked appropriately. Controlled drugs are checked weekly and the register is maintained.</p> <p>A safe system for medicine management is observed on the day of the audit. The GP interviewed stated that there have been no medication errors in which the GP has been involved with. The registered nurses contact the GP with any queries or point of clarification as needed. There is clear evidence of medication reconciliation and the pharmacy completes pharmacy audits six monthly.</p> <p>The medication records reviewed are reviewed monthly or more often if needed. The date is recorded and the record signed off by the GP. All medicines are prescribed individually on the records reviewed. There is a staff signature specimen register maintained for all staff who administer medicines. The individual resident medication records evidence photographic identification. The medication signing records are completed by the pharmacist and as each medication is administered it is signed off by the registered nurse.</p> <p>Medication fridge monitoring occurs and records sighted. There are no residents self-medicating medications except for the use of inhalers. The GP has reviewed these residents and approved the use of the inhalers. A self-medication policy is documented and implemented. A schedule was sighted for administration of Vitamin 12 injections to be administered three monthly by the registered nurses.</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 kitchen staff interviewed (one cook and one kitchen hand) both work Monday to Friday, and a cook and a trained kitchenhand work the two days in the weekend and provide relief as required. All kitchen staff are fully informed about food handling and practices to meet all</p>

		<p>requirements. The food safety management education undertaken is appropriate to service delivery.</p> <p>Policies, procedures and guidelines are available that are current and up-to-date and include a separate cleaning schedule, temperature requirements, hygiene standards for staff, purchasing of food, checking deliveries, storage and waste management.</p> <p>Regular monitoring and surveillance of the food preparation and hygiene is performed. A menu audit was completed on 3 March 2014 by a registered dietitian. The menu rotates and summer and winter menus are prepared. The dietitian is available by a referral, but does visit on a monthly basis. The kitchen is well designed and functional.</p> <p>A nutritional profile is completed for each resident as part of the interRAI assessment process on admission and this information is shared with the kitchen staff to ensure all needs, wants, preferences and special diets are catered for.</p> <p>The families and residents interviewed reported satisfaction with the meal service.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complies with current legislation and guidelines. There is evidence of fridge/freezer temperature recordings which met food safety requirements.</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>	FA	<p>The registered nurse interviewed reported that their service does not refuse a resident if they have a suitable needs assessment service coordinators assessment (NASC) for the level of care and that there is a bed available.</p> <p>In the event that the service cannot safely meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be arranged. This could occur as an example in the event of a resident requiring a secure dementia service for ongoing dementia care. The service provides rest home and hospital level care to residents.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	FA	<p>All new residents admitted to this service have an interRAI assessment completed or in progress. The first interRAI is completed</p>

gathered and recorded in a timely manner.		<p>within twenty four days of admission. The assessments include the review of any previous interRAI assessments such as homecare and/or needs assessment service coordinators comments. Any additional assessments are completed such as continence, pain, cultural, skin pressure areas prevention, falls risk assessments, nutritional, and other assessments as required specific for the individual resident.</p> <p>The residents' records reviewed evidenced the electronic assessments are currently printed off and included in the hard copy residents' records. Results of the assessments are discussed with the resident and family/whānau and included in the care plan as needed.</p> <p>Residents, staff and families interviewed reported appropriate care is provided that meets identified needs.</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' records have care plans that address resident's current abilities, level of independence, identified needs/deficits, and takes into account the resident's habits, routines and idiosyncrasies. The strategies for minimising falls risk on assessment and use of techniques that are effective were evidenced in the records reviewed. The interRAI assessment has an assessment summary which includes triggered outcome scores and the needs, identified by the registered nurse completing the individual resident assessment. These findings are documented onto the care plan.</p> <p>The clinical leader and registered nurses interviewed demonstrated understanding of the interRAI process.</p> <p>The care plans and activities plans identified resident's individual activities, motivational and recreational requirements with documented evidence of how these are managed effectively for the individual resident. Appropriate interventions were documented on each care plan sighted.</p> <p>The individual resident's records sampled included two rest home and five hospital level residents. The records demonstrated integration with dividers between each section and a contents page with a list of the contents.</p> <p>The clinical leader, registered nurses, general practitioner and</p>

		healthcare assistants reported they receive adequate information to assist with the continuity of care for each individual resident.
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>As observed on the days of the audit and from review of the care plans, support and care was individualised and focused on achieving desired outcomes/goals set. The clinical leader, registered nurses and healthcare assistants interviewed demonstrated good skills and good knowledge of the individual needs of residents. The residents' records showed evidence of consultation and involvement of the family. The residents interviewed reported satisfaction with the care and services provided.</p> <p>Short term care plans are developed as necessary for any event that is not part of the care plan, such as weight loss and wound/skin tears management.</p> <p>The service has adequate stocks of wound and continence products to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the residents' needs being able to be met. Observations on the day of audit indicated residents are receiving care that is consistent with their needs. The clinical leader and registered nurse interviewed reported that all care plan interventions are accurate and kept up to date.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme ensures residents' individual motivational, recreational and cultural needs are recognised. Each resident is assessed on admission to the service. The residents have the opportunity to maintain interests, choices and activities in a continuing care environment. The activities programme sighted is based on the residents' needs, interests, skills and strengths and covers cognitive, physical and social needs.</p> <p>The activities programme implemented is planned on a monthly basis. A copy of the programme is displayed on the notice board accessible to most residents and families. Residents receive a copy weekly to have in their individual rooms. A resident meeting is held monthly, minutes of the meetings are available and a copy displayed on the notice board.</p> <p>An attendance record is made of each resident's participation.</p>

		<p>However, it is voluntary to attend and this is respected. One on one activities are arranged for the hospital level residents who are unable to attend the group sessions. Each resident's activities plan is reviewed six monthly to ensure goals are evaluated and updated as required.</p> <p>Residents are encouraged to maintain links with family and the community. The service hires a van for outings. Special days are celebrated, for example birthdays, anniversaries, cultural days and other special events.</p> <p>Christian groups visit and church services are held weekly. Communion is available.</p> <p>Residents were visibly enjoying the activities seen during the audit and residents interviewed reported that they enjoy the range and variety of planned activities arranged.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Care plan and activities plans are reviewed six monthly or more often if required. Evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the set goals. If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with their GP. Residents' changing needs are clearly described in the care plans reviewed. Short term care plans are instigated if and when required. Short term care plans are developed for wound care, infections, mobility changes, weight loss or other reasons. These processes are documented on the short term care plan, medical and nursing notes and the resident's progress notes.</p> <p>The healthcare assistants interviewed demonstrated good knowledge of short term care plans and reported that these are identified and information is shared at handover between shifts.</p> <p>Families reported that they can consult with staff at any time if they have any concerns or when there are changes in the resident's condition. This is documented on the family communication sheet in all records reviewed.</p> <p>There was no evidence that multidisciplinary reviews are being undertaken in the files reviewed.</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>	<p>FA</p>	<p>Residents are provided with options if required to access other health and disability services. There is a GP who is contracted to the facility and the GP visits at least monthly for the hospital level residents and/or three monthly for those receiving rest home care and management. The GP visits as required after hours. The GP arranges any referral to specialist medical or surgical services as necessary.</p> <p>The clinical leader interviewed reported that referral services respond promptly to referral sent. Records of the processes maintained is able to be confirmed in the residents` records reviewed which includes referrals and consultations with mental health services, general medical or surgical services, radiology, gerontology nurse specialist, podiatry and dietitian input. The GP interviewed reported that appropriate referrals to other health and disability services are well managed at the service.</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>	<p>FA</p>	<p>All chemicals are securely stored. Storage areas both inside and outside are locked. Chemicals are clearly labelled and safety data sheets are available. Staff confirmed that they can access personal protective clothing and equipment at any time. As observed, disposable gloves and gowns are worn when required. Waste management meets legislative requirements.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current warrant of fitness.</p> <p>Maintenance is undertaken by both internal maintenance and external contractors. Electrical safety test tags show this occurred in April 2015. Clinical equipment is tested and calibrated by an approved provider at least annually or when required. This was last conducted in December 2014.</p> <p>The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is secure, bathroom floors are non-slip, and walking areas are not cluttered.</p> <p>The service documents regular maintenance and documentation identifies contractor usage as appropriate such as electricians. There are easily accessed shaded outdoor areas. Plastic chairs and rusty</p>

		<p>outdoor tables were removed on the day of audit. The cupboards in the sluice room and the laundry cannot be cleaned to meet infection control standards.</p> <p>Interviews with residents and family/whānau members confirmed the environment was suitable to meet their needs.</p> <p>The new owner is buying the business only. The building will remain in the ownership of the current owner. No changes to the building footprint are planned.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></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>	PA Low	<p>Twenty of the residents' bedrooms have full ensuite facilities and 22 bedrooms have toilet and hand washing facilities only. The resident shower and toilet areas that are centrally located have privacy locks to ensure residents can attend to their personal hygiene without interruption. There is a designated staff/visitor toilet.</p> <p>Minor issues found on the first day of audit such as chipped paint and one hand basin which required repair were repaired the same day. The prospective owner is aware of the repairs undertaken.</p> <p>Hot water temperatures are checked monthly. Not all temperatures sighted meet safe legislative standards required for aged care facilities.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Bedrooms are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings. Currently all bedrooms are single occupancy.</p> <p>Resident and family/whānau members interviewed did not identify any concerns related to personal bed space or privacy.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining</p>	FA	<p>Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. The dining and lounge areas are separated. The areas are appropriately furnished to meet residents' needs. One lounge is generally used for activities as observed and there is a second lounge which contains a library area and is used as</p>

needs.		<p>a quiet area.</p> <p>Residents and family/whānau voiced their satisfaction with the homely environment.</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>There are dedicated storage areas for cleaning chemicals. Resident personal belongings are laundered on site as part of the health care assistants' daily routine. Other laundry is contracted out and picked up and delivered daily.</p> <p>There are dedicated cleaning staff. A daily task list of duties was sighted which the cleaner stated they have time to complete.</p> <p>The proposed new owner stated she intends to increase cleaning hours as there is currently no dedicated spring cleaning programme in place.</p> <p>Residents and family/whānau members interviewed had no negative comments related to cleaning or laundry.</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>	PA Moderate	<p>Policies and procedures guide staff actions in the event of an emergency. There is an emergency plan which includes the approved fire evacuation scheme. Policy identifies that six monthly emergency education, training and fire drills will be conducted for staff. This has not occurred.</p> <p>All resident areas have smoke alarms and a sprinkler system to meet building code requirements.</p> <p>Emergency supplies and equipment include food and water. Emergency stock is kept in locked bins. The emergency stock bin check lists identify that regular checking is not being undertaken. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ.</p> <p>Staff are required to ensure all doors and windows are secured after hours. Documentation identifies that this happens at least twice a night. There are outdoor security lights. Staff interviewed confirmed they feel safe at all times.</p> <p>There is a call bell system available for residents and staff to call for assistance if required.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The facility is kept at a suitable temperature throughout the year via under floor central heating and the opening of doors of windows for ventilation. This was confirmed during resident and family/whānau interviews. The facility was very warm on the days of audit.</p> <p>All resident areas have at least one opening window to provide adequate natural light.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service has a documented infection control programme which is reviewed as part of the annual review. The infection control programme aims to minimise the risk of infections to residents, staff, family / whānau and visitors to the facility. The organisation is a member of an external specialist infection control service. The policies and procedures are additional reference and resource material which is accessible for all staff.</p> <p>The infection control co-ordinator (ICC) is the clinical leader. A job description is available which states clear guidelines for the accountability and responsibilities involved with this role. The ICC monitors all infections, uses standardised definitions to identify infections appropriately, surveillance and monitoring of organisms, related to antibiotic use. Monthly records are maintained. Infection control is presented at each staff meeting.</p> <p>The ICC interviewed reported staff fully support the programme and have good assessment skills in the early identification of suspected infections. This was also addressed with the healthcare assistant interviews and care staff are skilled and ensure they notify the registered nurses if any concerns when caring for the residents. The shift handover observed is a forum for reporting incidences of infection. Short term care plans are used, for example for wound care and other infections and fluid balance records are also discussed.</p> <p>A process is identified in policy for the prevention of exposing others to infection. Staff interviewed knew when not to come to work and when to return. Signage is used in the facility as required. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Infection control advice can be sought from the GP, microbiologist, the specialist advisory service and from representatives of the DHB infection control</p>

		<p>team if and when required. The GP interviewed is well informed of obligations and reporting systems if needed for notifiable infection outbreaks or diseases.</p> <p>The clinical leader ICC interviewed demonstrated good prevention and control techniques and awareness of standard precautions. There have been no outbreaks of infection since the last audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical leader has the role of infection prevention and control co-ordinator. The infection control committee meets quarterly and report any issues to the monthly staff meetings. The committee consists of the ICC, two health care assistants, one cook and one cleaner/laundry staff members. External specialist advice is available if and when required for the DHB infection control team, the diagnostic service and the GP. The externally contracted specialist infection control advisor also provided study day opportunities for all staff to attend. The clinical leader, registered nurses and healthcare assistants interviewed demonstrated good knowledge of infection prevention and control.</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>	FA	<p>The infection control manual, reviewed January 2015, sets out the expectations the service uses to minimise infections. This is supported by the infection control policies and procedures and the external specialist service's reference/resource manual which was sighted. Specific infection control areas, such as antibiotic use, methicillin resistant staphylococcus aureus (MRSA) and other antimicrobial screening, wound care management, blood and body spills, cleaning and disinfection are covered. Laundry and cleaning policies and procedures are developed and implemented specifically for the relevant services provided. Standard precautions are adhered to throughout all areas of service provision.</p> <p>Observations at the onsite audit identified the implementation of infection prevention and control procedures. Staff demonstrated safe and appropriate infection prevention and control practices.</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>	FA	<p>Infection control education is included in the orientation and as part of the ongoing in-service education programme provided annually as sighted on the nurse manager's training calendar 2015. The infection prevention and control education is provided by the infection control</p>

		<p>co-ordinator and external specialists as required. A study day is planned and is displayed on the staff notice board. Education evidence was filed electronically and could not be accessed on the day of the audit (Refer criterion 1.2.7.5).</p> <p>The ICC and healthcare assistants interviewed demonstrated good knowledge of infection prevention and control. Resident education is conducted as required. Hand hygiene foremost is encouraged by all staff.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection control surveillance that is undertaken is appropriate to the size and complexity of the service as shown in the infection control programme. All staff are required to take responsibility for surveillance activities as shown in the policy reviewed. A notification of infection form is completed as soon as signs and symptoms have been identified and given to the ICC. Monitoring is described in the infection control plan to describe actions taken to ensure residents` safety.</p> <p>The ICC completes the monthly infection surveillance report. The ICC monitors all urinary infections (UTIs), eye infections, upper and lower respiratory tract infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections. One resident has an indwelling urethral catheter and one a suprapubic catheter but risks are minimised with good techniques utilised by staff undertaking procedures for these residents as needed. The monthly analysis of the infections includes comparison with the previous month, reasons for the increase or decrease of infections and actions taken to reduce infections. The analysis includes the feedback summary that is provided to staff.</p> <p>The surveillance programme results are discussed at the staff meetings held 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>Policy indicates the service is committed to providing a restraint free environment. There are procedures in place to guide staff should restraint be required. Policy identifies that the use of enablers is voluntary and should be the least restrictive option to meet the needs of the resident to promote independence and safety. Staff were aware of the difference between an enabler and a restraint and what actions need to be taken related to the use of both. At the time of audit the</p>

		<p>service had no restraint or enablers in use.</p> <p>Policy states staff undertake bi-annual education related to restraint minimisation. (The dates of restraint education could not be confirmed. Refer comment in criterion 1.2.7.5). Staff were able to verbalise de-escalation methods used to prevent any restraint use.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>The service has a complaints register. The last entry made was in July 2013. The facility manager confirms that minor complaints are addressed at the time they are received and that there are no outstanding issues. This is supported by one resident and one family/whānau member who describe two minor complaints which they made that have been fully addressed. There is no documented evidence available to show how these issues were addressed.</p>	<p>No documentation could be found related to two complaints of a minor nature described during resident interviews. Neither complaint is shown in the complaints register sighted.</p>	<p>Ensure all complaints have documentation and include the follow up actions taken to resolve the complaint.</p> <p>180 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated</p>	PA Low	<p>The service has systems in place for the collection, analyse and evaluation of key components of service. The facility manager</p>	<p>The service has a standardised template for recording staff meeting minutes which is not currently being used. The</p>	<p>Provide evidence that the standardised meeting minute template is being used to show how data related to the</p>

<p>and the results communicated to service providers and, where appropriate, consumers.</p>		<p>stated that results are discussed at staff meetings. This could not be confirmed in documentation sighted. Quality actions taken, such as falls management the reduction of medication errors, have been documented but no goals have been set.</p>	<p>information in recent staff meeting minutes does not indicate that quality information is shared with staff. Corrective actions have been shown for issues that quality data shows require improvement, such as the number of resident falls and medication errors. However as there are no set goals related to the corrective actions put in place. This made the process fragmented and does not allow evaluation of actions to be measured.</p>	<p>key components of service delivery are communicated to staff regularly. Identified goals for corrective actions are documented so these can be evaluated for effectiveness.</p> <p>180 days</p>
<p>Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>PA Low</p>	<p>Policy indicates that the internal annual audit process is one of the processes which is used to measure achievement against the quality and risk management plan. The annual audit plan sighted had not been completed to identify dates when audits would be undertaken during the year. At the time of audit seven of the 21 annual audits had been completed. Corrective actions were documented on the bottom of completed audits as required.</p>	<p>There is a documented annual audit schedule which does not show what dates audits will be undertaken. Audits are carried out on an ad-hoc basis when time allows and this does not meet policy requirements. The 14 outstanding audits, which are required to be undertaken by December 2015, had no allocated dates.</p>	<p>Provide evidence of dates allocated to the annual audit plan to show how all audits will be completed within the 12 month period as stated in policy.</p> <p>180 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>Policy contains an education plan which guides the education offered. This plan identifies how all essential education is met over a two year period and includes infection control and restraint management. The</p>	<p>The education plan sighted does not identify the date education occurred and no educational content was available on the days of audit. Individual staff education records could not be accessed as this information can</p>	<p>Provide evidence that staff education is appropriate for the role staff undertake and that policy requirements are met related to identified essential education. Staff annual appraisals are kept up</p>

		<p>education plan sighted showed intended education to occur each month but this could not be verified.</p> <p>There is a schedule in place showing when staff appraisals are due. This identifies some staff appraisals are overdue.</p>	<p>only be accessed electronically by the administrator who was away on holiday.</p> <p>Two of seven staff files reviewed did not have up to date annual appraisals as required to meet DHB contractual requirements (D17.7f).</p>	<p>to date.</p> <p>180 days</p>
<p>Criterion 1.2.9.1</p> <p>Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.</p>	PA Low	<p>Personal information is entered in all residents' files sighted. All entries are documented clearly and are legible with appropriate signatures and designations as required. The resident register is maintained. Resident current records are stored appropriately and securely.</p> <p>The records archive room was reviewed. The room is kept locked as required. The room is warm but is not set up with shelving. Records are currently stored in boxes. No system is documented to retrieve records as required. There are many records that have not been stored and were sighted in the nurses' office. It is a responsibility currently for the night staff to sort and file records for archiving.</p>	<p>The service does not have a system in place related to the management of archived records. This makes it very difficult to retrieve information. No dates are shown related to when resident information was archived (all records are three years old or less as the previous owner took all archived records with them).</p>	<p>Provide evidence that a system is in place related to the management of archived residents' records.</p> <p>180 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response</p>	PA Low	<p>The clinical leader was available for interview. Resident records were randomly selected and reviewed. There was no clarity</p>	<p>There is no documented evidence in the individual residents' records reviewed of multidisciplinary reviews being</p>	<p>Provide evidence that the process for multidisciplinary reviews is implemented and reviews are undertaken.</p>

to the support and/or intervention, and progress towards meeting the desired outcome.		around multidisciplinary reviews being completed. New forms has been developed and implemented for multidisciplinary reviews to occur and a list of all residents is available with dates of reviews to be arranged. None have yet been completed.	undertaken.	180 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	All processes are undertaken to ensure the facility maintains a current building warrant of fitness. Regular maintenance is undertaken to provide a safe environment for residents. Not all existing fittings can be cleaned to meet infection control standards.	The doors and shelf in the cupboards under the sink in both the laundry and in the sluice room have been exposed to water damage and are very warped. They cannot be cleaned to meet infection control standards.	Provide evidence that all buildings, plant and equipment comply with requirements to provide a safe environment, including being able to be cleaned to meet infection control standards.  180 days
Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.	PA Low	There are adequate numbers of toilets and showers located at the facility. This includes a separate visitor and staff toilet. Hot water temperatures are undertaken monthly. Not all findings are within the required safe temperature range for aged care.	Whilst the water temperatures for hand basins meet legislative requirements the shower temperature recordings exceed safe requirements. Temperature readings for the shower area exceeded 45oC on 11 of the 12 months sighted. No follow up actions have been taken.	Provide evidence that all water temperatures are maintained at or below 45oC at point of exit for resident use. This includes shower temperatures.  180 days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire	PA Moderate	Staff cover emergency procedures as part of their orientation. Policy states six monthly fire evacuations and emergency management education will be conducted. The last fire evacuation drill occurred	The service has not had a fire drill since September 2014.  There are four bins which contain emergency supplies, including food. The checklists sighted were last completed in 2014 and identified that some items,	Ensure fire drills, which include emergency evacuation and staff education are undertaken six monthly to meet legislative and policy requirements.  Emergency supplies are kept

safety and emergency procedures.		one year prior to this audit. There is a large supply of emergency equipment and stores but regular checks for expiry dates are not occurring.	including food items are now past the expiry date shown.	up to date and checked regularly.  90 days
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.