Tranquillity Bay Care Limited

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Tranquillity Bay Care Limited
Premises audited:	Tranquillity Bay Care
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 January 2016 End date: 12 January 2016

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

Tranquillity Bay Care Limited (known as Tranquillity Bay Care) can provide care for up to 34 residents requiring rest home level care with an occupancy of 19 residents on the day of audit. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the District Health Board contract.

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

The manager is responsible for the overall management of the facility. Service delivery is monitored.

The improvement required at the last provisional audit to staff training around first aid has been addressed.

This surveillance audit identified improvements required to the following: resident agreements, the quality and risk management programme, human resources, wound management, the activities programme, management and administration of medication, and review of the menu.

Consumer rights

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

Staff interviewed are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and care for the residents. Information regarding the complaints process is available to residents and their family and complaints reviewed are investigated with documentation completed and stored in the complaints folder. Staff communicate with residents and family members following any incident. Some resident agreements are in the name of previous owner/s.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Tranquillity Bay Care Limited (known as Tranquillity Bay Care) has implemented the Radius quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and the manager reports allow for the monitoring of service delivery. The registered nurses and the manager review clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented.

Improvements are required to the review of quality data, regularity of meetings, evidence of resolution of issues and review of risks and hazards.

Staffing levels are adequate across the service with human resource policies mostly implemented. Improvements are required to review of practicing certificates, criminal vetting, staff contracts, referee checks and orientation.

Continuum of service delivery

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

Service delivery provides care to residents assessed as requiring rest home level care. The registered nurses develop, review, update and evaluate residents' care plans as per policy. Residents or their family state that they have input into the development and review of care plans. Residents and family interviewed are satisfied with the standard of care provided by staff. An improvement is required to wound management.

The activity programmes support the interests, needs and strengths of residents although improvements are required to the programme.

A medicine management system is implemented, with policies and procedures recording service providers' responsibilities. Improvements are required to documentation of residents' allergies/sensitivities, photograph identification of residents, three monthly medication reviews completed by general practitioners and annual staff medication competencies.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Residents' dietary needs are identified on admission, documented in nutritional profiles, and reviewed on a regular basis. Residents confirmed that adequate fluids are provided and snacks are available between meals. Review of the menu is required.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

There is a current building warrant of fitness. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family interviewed describe the environment as appropriate with indoor and outdoor areas that meet their needs. Indoor and outdoor areas are being extensively refurbished.

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.

Documentation of restraint minimisation and safe practice policies and procedures and implementation, demonstrate residents were experiencing services that are least restrictive. There is no restraint or use of enablers at the service.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

Surveillance data is collected monthly. Appropriate interventions are in place to address the infections. Surveillance data is graphed and discussed by the registered nurses and manager.

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	10	0	4	3	0	0
Criteria	0	31	0	13	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisation's complaints policy and procedures are in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include timeframes for responding to a complaint. Complaint forms are available in the facility and family and residents interviewed know where they can get a form. The complaints register in place includes: the date the complaint was received; summary of the complaint; corrective actions taken and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaints folder. There have not been any complaints lodged since the new ownership in May 2015. There have not been any complaints with the Health and Disability Commission (HDC) or other authorities since the last audit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	PA Low	Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accidents/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is available.

communication.		Family are informed if the resident has an incident, accident, a change in health or a change in needs as confirmed in a review of 10 accident/incident forms and in the resident files. Files reviewed include documentation around family contact. Interviews with family members confirm they are kept informed. Family confirm that they are invited at least six monthly to the care planning meetings for their family member. Interpreting services are available when required from the District Health Board. The manager states that families are involved in resident care and can interpret when required. There are no residents requiring interpreting services. All residents interviewed confirm that staff are approachable and communicate well. Information about the service is available in large print and staff interviewed advised that this could be read to residents. Each resident reviewed has a signed agreement completed on the day of admission. Some agreements are still in the name of the previous owner. A link provider from the district health board was interviewed and stated that the care provided was excellent, that the manager was approachable and resident focused and that the staff and manager had gone out of their way to ensure that resident rights were fully upheld.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The organisation is owned and operated by Tranquillity Bay Care Limited. The strategic direction for the organisation is documented. The purpose, values, scope, direction, and goals of the organisation are clearly identified and reviewed by the director known as, and operating as the manager. There is an established organisational structure, with the sole director being supported by an operations manager. The director has a background in administration and accounting and has been working in the aged care industry for five years. The manager is supported by a senior registered nurse who has extensive experience in aged care. The registered nurse provides clinical oversight of the service. The operations manager provides support for property development and refurbishment of the site.
Standard 1.2.3: Quality And Risk Management Systems	PA Low	Tranquillity Bay Care has purchased the Radius policies, procedures and quality and risk management framework that is documented to guide practice. The Radius business plan 2015-17 is documented and there is a transition plan developed by the manager to guide

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		improvements required. The plans are reviewed by the director/manager and director with input from key staff at the transition meetings held fortnightly. The service implements Radius organisational policies and procedures to support service delivery. All policies are subject to reviews as required, with all policies current and some having been reviewed by the manager. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Service delivery is able to be monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. An improvement is required to documentation of evidence of resolution of issues as these arise. There are bi-monthly staff meetings with these held as needed to date. There are newly implemented quality and infection control meetings which are intended to be held monthly. The first quality and infection control meeting has been held. There are fortnightly transition meetings. An improvement is required to implementation of the meeting schedule. All staff interviewed report that they are kept informed of quality improvements and describe the manager as being open and transparent. The organisation has a risk management including a hazard programme in place that includes an organisational risk management plan with an improvement around review required. Health and safety policies and procedures are also in place for the service. Any hazards identified are signed off as addressed or risks are minimised or isolated. The last resident satisfaction survey was completed by the previous owner in 2013. The manager states that the intention is for the residents to complete a satisfaction survey in the future. In the meantime, resident meetings have been held quarterly with this forum used as an opportunity to discuss issues and receive feedback. Residents interviewed state that they feel comfortable in raising issues and in making suggestions. There has been a resident satisfaction survey around food services.
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	FA	The manager and registered nurse are aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks. Times when authorities have had to be notified are documented and retained on the relevant file. This includes notification of the change of owner to HealthCERT. The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff records reviewed demonstrate that staff receive

manner.		education at orientation on the incident and accident reporting process with an annual competency completed by staff. Staff interviewed understand the adverse event reporting process and their obligation to documenting all untoward events. Incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is able to be shared with staff and residents (refer 1.2.3) with incidents graphed. The senior registered nurse reviews and signs off all incidents and accidents with the manager involved as required.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	Human resource policy and processes are in place. The senior registered nurse and other RN holds a current annual practising certificate with one receiving confirmation of a current certificate on the day of the audit. Visiting practitioners' practising certificates reviewed are current with these confirmed on the day of audit and include the general practitioners, pharmacists and podiatrist and physiotherapist. Staff files include employment documentation such as job descriptions, contracts and appointment documentation on file. Evidence of some criminal vetting is on file. An annual appraisal process is in place with staff having had a performance appraisal prior to the new owners taking over. A comprehensive orientation programme is available for staff. Some staff files show completion of orientation. Staff are able to articulate the buddy system in place and the orientation sign off process completed. Training is provided with an annual training plan in place. Evidence of training was sighted with attendance sheets and signing of individual competencies. Registered nurses have training relevant to their role including topics such as pain management, oxygen use, wound management, diabetes and continence. Education and training hours exceed eight hours a year for all staff reviewed.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced	FA	The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy. There are always two health care assistants on duty on morning and afternoon shifts and a

service providers.		health care assistant overnight. The registered nurse and manager are on call 24-hours a day. Residents and families interviewed confirm that staffing is adequate to meet the residents' needs. There are 22 staff at the time of the audit including the manager, the registered nurse (senior) and registered nurse who job share work five days a week, an activities coordinator, maintenance staff and health care assistant. Household staff are appointed including cooks and a cleaner.
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	Medicine management policies and procedures are in place and implemented and include processes for safe and appropriate prescribing; dispensing; and administration of medicines. Medicine charts list all medications the resident is taking. Medication charts are signed by the general practitioner. All entries are dated. Allergies are recorded in most files. Some charts have photo identification. Discontinued medicines are signed and three monthly GP medication reviews are mostly completed at scheduled times documented by the doctor in the resident record. All medicines are prescribed by the general practitioner. Medication reconciliation policies and procedures are implemented. Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. Controlled drugs are checked weekly by two clinical staff members. Unwanted or expired medications are collected by the pharmacy. During the breakfast and lunchtime medication administration rounds observed, the staff member completed the round according to the requirements for safe and appropriate medicines administration. Most staff who are authorised to administer medications have completed medication competencies. Self-administration of medicine policies and procedures are in place and sighted. Four residents self-administer some of their own medications. All residents who self-administer medicines have signed a form completed by the general practitioner indicating that they are competent and able to self-administer medications. All have secure storage for their medicines and the registered nurses check to ensure the medicines have been taken. There is no evidence of transcribing. Medicines charted as being administered when required (PRN) are documented with timeframes for administration with most having indications for use documented. At times, the effect of the

		PRN medication is documented.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low	Individual food, fluids and nutritional needs of residents are met. The meals are prepared and cooked on-site. The manager states that menus have been reviewed by the dietitian employed by the previous owners however this was not able to be sighted. The menu review is based on nutritional guidelines for the older people in long-term residential care and rolls over every four weeks. Dietary assessments are completed on admission by the registered nurses. This information is shared with kitchen staff to ensure all needs, food allergies, likes, dislikes and special diets are catered for. The facility provides modified diets for example; puree diets to meet the dietary needs of the residents. The cook interviewed confirmed documented kitchen routines for cleaning and routine checks; for example, temperature checks of the fridges, freezers and food. Nutrition and safe food management policies define the requirements for all aspects of food safety. Labels and dates on all food containers are maintained. The cooks and the operations manager, who cooks at times, have current food handling certificates.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Interventions are documented for each goal in the care plans reviewed. Assessments reflect additional considerations for example: pain management; dietary likes and dislikes; gait and balance. Residents and family involvement in the development of goals and review of the care plans is encouraged and confirmed during resident interviews. Multidisciplinary meetings are conducted annually. Interventions from allied health providers are recorded for example notes from the podiatrist. Two files were reviewed for residents requiring dressing of wounds. Improvements are required to documentation of wound management.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their	PA Low	Residents confirm they have choices regarding what activities they participate in and contribute to planning their own activities. The activities coordinator and a health care assistant provide activities for the residents three days a week for four hours each day. There are also outings for residents who state that these are meaningful and relevant to their abilities and age. Weekly

needs, age, culture, and the setting of the service.		activities also include church and library visits and happy hour. Physical activities are not scheduled however residents are able to walk around the grounds which have extensive grassy areas and paths available. Residents and family confirm they are satisfied with the activities programme on the whole however improvements are required. Each resident has access to an activities programme and there is a whiteboard which displays activities in the communal area. On admission the registered nurse and activities coordinator complete an assessment for each resident. An activities plan is identified and reviewed with input from residents. Review of activity plans showed six-monthly reviews that are now in line with review of each resident's care plan.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The residents' files reviewed show that care plans are reviewed at six monthly intervals. Reviews are also documented in the multi-disciplinary review (MDR) records annually. Members of the allied health team document in the client records. Progress notes reflect daily response to interventions and treatments and are completed by the health care assistants and registered nurses. Continuity of care is reflected in the progress notes and at handover. Changes to care are documented in the care plans. Residents are assisted in working towards their goals. Short-term care plans are developed for acute problems for example infections and other short-term conditions.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date May 2016). There have been no building modifications since the last audit however there is refurbishment of the interior and of decks that has been completed. A planned maintenance schedule is implemented and the maintenance staff and documentation confirmed implementation of this. There is a lift between the ground and lower floors. Currently the lower floor with bedrooms, toilets, lounge areas and kitchenette is not in use as current occupancy is not able to sustain this. Areas in use have lounge areas that are designed so that space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids. There are quiet areas for residents to sit. Equipment relevant to care needs is available and staff confirm that there is always sufficient. A

		test and tag programme is in place. Equipment is calibrated. There are safe external areas for residents and family to meet/use and these include paths, seating and shade.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	An evacuation plan is approved by the New Zealand Fire Service. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place at least six monthly with individual training for staff annually. The orientation programme includes emergency and security training. Staff confirm their awareness of emergency procedures. There is always one staff member at least with a first aid certificate on duty. The previous improvement has been met. All required fire equipment is checked within required timeframes by an external contractor. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. Emergency lighting is in place. The doors are locked in the evenings. Systems are in place to ensure the facility is secure and safe for the residents and staff. External lighting is adequate for safety and security with sensor lights on the outside of the building. The call bell system has been replaced with an external company on call with answering of call bells able to be monitored. The call bell system works wirelessly but can operate on battery or on mains. Calls are displayed on a pager held by staff.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organization. Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators on the managers' report with the registered nurses and manager discussing data (refer 1.2.3). Residents with infections have short-term care plans completed to ensure effective management and monitoring of infections. Quality indicators are to be reported monthly at staff, quality, and infection control meetings. Interviews confirmed information relating to infections is made available for care staff during hand over.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a policy around use of restraints and enablers however these are not used in the facility. Staff are able to describe potential use of restraint and enablers. The registered nurse is appointed in the role of the restraint coordinator. Review of the potential use of any restraint is expected to occur at the quality and infection control meeting (refer 1.2.3). The registered nurse states that any use of enablers would be voluntary.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Some agreements are still in the name of the previous owner/s.	Not all resident agreements reviewed are in the name of the current owner.	Ensure that all resident agreements are in the name of the current owner. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Service delivery is able to be monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. Quality improvement data is collected. The manager has developed a report that summarizes data from incidents, accidents, infections and data around other indicators. Graphs have been developed that identify key indicators. The data and	Quality data is not reviewed at regular intervals with evidence that the results are communicated to service providers and, where appropriate, residents.	Analyse and evaluate quality data and use for improvement of services. 90 days

		graphs are intended to be tabled at regular meetings (refer 1.2.3.7) with the information used to review trends. The internal audit schedule is documented with evidence that this has been implemented by the previous owners with corrective action plans and evidence of resolution documented. The senior registered nurse states that the internal audits have been completed and this is confirmed by the manager. Documentation of completion of internal audits was able to be sighted on the day of the audit however not all corrective action plans had evidence of resolution of issues (refer 1.2.3.8).		
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	Meetings have been established. The transition meeting with key members of staff including the manager is held fortnightly with minutes documented. There is a newly established quality and infection control meeting with the first meeting held in January 2016. There are ad hoc staff meetings.	Meetings have not been held regularly to date with all aspects of the quality and risk management programme discussed at each meeting.	Implement the meeting schedule with all aspects of the quality and risk management programme discussed at each meeting. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Internal audits have been completed as per schedule. There is evidence that corrective plans are documented. A food satisfaction survey has been completed in July 2015.	Resolution of issues identified in corrective action plans is not able to be sighted including issues identified in audits and through surveys.	Document resolution of issues identified through internal audits, surveys and other data collected as issues are identified.

				90 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Low	An organisational risk management plan dated October 2013 and documentation of hazards has been developed in the past by a previous owner.	There is no evidence of review of the organisational risk management plan or of the development of a current risk management plan or review of the hazards documented.	Review the previous risk management plan and hazard table and update. 90 days
Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	The registered nurse had an expired practicing certificate but received confirmation on the day of the audit from the New Zealand Nursing Council that there was a current certificate held. Other practicing certificates for visiting health professionals were on file as being out of date but were confirmed on the day of the audit as being current.	The service has not yet implemented a process to ensure that practicing certificates are current.	Ensure that any staff member or visiting practitioner required to have a practicing certificate has one that is current. 90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Three of the five staff files reviewed included evidence of a criminal vetting process. All files have consent for criminal vetting on file. All staff files reviewed have a signed	Two of the five staff files do not show evidence of criminal vetting. ii) Four of five staff files reviewed have a signed relevant	Ensure that all staff are vetted for criminal activity. ii) Ensure that all staff have a contract with

		relevant contract on file. One of the contracts is in the name of Tranquillity Bay Care and the others are in the name of the previous employer. Referee checks have not been completed consistently in the past for new staff and a review of one new staff member appointed by Tranquillity Bay Care Ltd did not include documentation of referee checks.	contract on file however these are not in the name of Tranquillity Bay Care Ltd. iii) Referee checks are not documented on all files reviewed.	Tranquillity Bay Care Ltd. iii) Ensure that evidence of referee checks is retained on staff files. 90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Three of five files reviewed show evidence of completion of an orientation programme.	Two of five staff files reviewed do not show evidence of completion of an orientation programme.	Ensure that all staff have completed an orientation programme. 90 days
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.	PA Low	An annual appraisal process is in place with staff having had a performance appraisal prior to the new owners taking over. Three of five files reviewed have a current performance appraisal on file.	Two of five employee files do not have an annual performance appraisal.	Ensure that all employees have an annual performance appraisal. 90 days
Criterion 1.3.12.1 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.	PA Moderate	Five of ten medication files reviewed have a photograph of the resident. Eight of ten medication files were reviewed three monthly by the general practitioner as scheduled.	i) Five of ten medication files reviewed do not have a photograph of the resident. ii) The photographs on file do not confirm that the photograph is a true likeness of the resident. iii) Two of ten medication	i) Ensure that there is a photograph of the resident on each file. ii) Document that each photograph is a true likeness of the resident. Iii) Ensure that each resident

			files were not reviewed three monthly by the general practitioner.	has their medication reviewed as per the documented timeframe on file. 60 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	Three of the five files reviewed include a current medication administration competency completed.	Two of the five files reviewed do not include a current medication administration competency.	Ensure that all staff administering medication have an annual competency completed. 60 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	PRN medication is charted for each resident requiring this by the general practitioner. Staff can describe what each PRN medication is for.	Not all PRN medication is charted with documentation of what the medication is for. ii) The effect of the PRN medication is not always charted.	i) Ensure that the PRN medication is charted with documentation of what the medication is for. ii) Document the effect of the PRN medication after this has been given. 60 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	The manager states that the previous owners had completed a dietician review of the menu.	Review of the menu by a dietitian was not able to be sighted.	Ensure that there is regular review of the menu by a qualified health professional. 90 days

Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Two files were reviewed for residents requiring dressing of multiple wounds. There are sound processes for documentation of wound care established. Assessments of wounds is being completed initially and on an ongoing basis at the end of each dressing change. There is evidence of documentation of most dressings completed both on the dressing form and in the wound folder progress notes. Notes are also recorded in the progress notes in the resident file. Frequency of change of dressings is recorded at the end of each dressing change. Progress of the wound is documented at the end of each dressing change. Health care assistants complete the dressing changes with oversight from the registered nurses.	Wounds are not always dressed as per frequency documented. ii) In one of the charts, it is difficult to identify which wound has been dressed and outcomes for each wound. iii) The wound register is not kept up to date. iv) The registered nurse does not document that they have had oversight of dressing changes and ongoing management of wounds.	i) Ensure that wounds are dressed as per frequency documented. ii) Identify which wound is being dressed and ongoing management of each wound. iii) Keep the wound register up to date. iv) Document oversight of wound management by the registered nurse on a regular basis. 90 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	An activities plan is developed with social and cognitive activities. Other activities are scheduled on a weekly basis such as church activities and outings. There are both group and one to one activities.	Physical activities are not scheduled for residents. Two of the seven resident/families interviewed stated that there were not enough activities and at times residents were bored and the activities did not include physical activities on a regular basis.	Review the activities programme to ensure that there are sufficient activities for residents and that these include scheduled physical activities. 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, these 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.