

# Ohope Beach Care Limited

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## 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:

<b>Legal entity:</b>	Ohope Beach Care Limited	
<b>Premises audited:</b>	Ohope Beach Care	
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care	
<b>Dates of audit:</b>	Start date: 14 January 2016	End date: 15 January 2016
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	32	

# 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.

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

### Key to the indicators

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

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

## General overview of the audit

Ohope Beach Care Ltd (referred to as Ohope Beach Care) can provide care for up to 36 residents requiring care at either rest home or dementia level with an occupancy of 32 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, review of residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The facility manager is responsible for the overall management of the facility and is supported by the clinical manager who is tasked with providing clinical oversight.

The following improvements required at the certification audit have been met: advance directives and consent; the complaints register; reporting to the governing body; regularity of resident and family meetings, some human resource issues, and environmental management improvements identified.

Improvements continue to be required to the following: quality and risk management systems including adverse event reporting; human resources; staffing; management of resident documentation; admission agreements; resident assessment, care planning and review; medicine management; maintenance of the building and safety of outdoor areas; and the call bell system. Improvements are also required to the activities programme and infection control programme.

There are standards identified as high risk. These are around adverse events, staffing, assessments, medication management and the call system.

## 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.		Standards applicable to this service fully attained.
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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. There is a complaints register which is up to date and improvements have been made to the consent form and advance directives.

## 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.
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The facility manager provides operational management. A business plan is reviewed but not current. There is regular reporting by the facility manager to the governing body.

Improvements continue to be required to the quality and risk management systems that includes review of policies and procedures analysis of quality improvement data, corrective action planning with evidence of resolution of issues and improvement to service delivery.

There is a documented rationale for determining staffing levels however improvements are required as all staff are based in the dementia unit until called or at regular intervals throughout the day.

## 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.
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Care plans and review of care is completed by the registered nurse, clinical manager and other staff in conjunction with the resident and/or the family. Consultation and liaison is occurring with other services as documented in resident notes. The general practitioner visits the facility weekly and states that there is good follow up instructions and identification of any changes to a residents needs in a timely manner. Residents, family and the general practitioner interviewed were positive around care and support provided.

Areas for improvement continue around assessment, care planning, review and reassessment that includes service delivery timeframes; completion of initial care plans; completion and evaluation of assessments; care plan interventions; care plan evaluations and the use of short term care plans.

There is an activities programme with individual 24-hour plans documented for residents in the dementia unit. There are areas requiring improvement around the 24 hour activities plans, activities staff and the activities programme.

There is a medication policy with medications administered in a timely manner. Improvements are required to the medication management and administration process.

The facility has a central kitchen and on site staff who provide the food service. 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. Residents confirmed that adequate fluids are provided and snacks are available between meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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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. Improvements identified at the previous audit required to the building have been addressed however other areas of repair are identified.

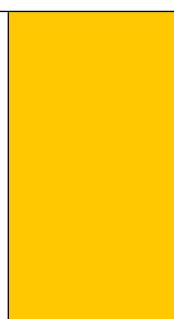
A call bell system is in place although improvements are required as if the call bells are activated by residents in the rest home, there is no audible sound as it rings in the dementia unit and staff come from the dementia unit to answer the call bell. Staff are not based in the rest home at all times.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Documentation of policies and procedures and the implementation of the processes, demonstrate residents are experiencing services that are least restrictive. The facility was not using restraints or enablers on audit days.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The infection control programme documents a policy around surveillance. A monthly report is documented and the number of infections are documented. Antibiotics are prescribed according to resident needs. Individual resident data is recorded in a number of places and does not always link. An improvement is required to surveillance of infection control data.

## 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	5	0	2	10	5	0
Criteria	0	28	0	4	19	5	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The resident files reviewed include a signed general consent form with family signing this if the resident is not competent to complete this. The informed consent form records consent for collecting and storage of resident information; routine procedures; consent to allow visiting personnel involvement and implementation of resident care under supervision of staff if it is beneficial to their leaning and work experience; use of photos for identification and display of relevant information and photos; and consent for environmental restraint for dementia residents. This now includes consent for outings and the previous improvement required at certification is met.</p> <p>The general practitioner determines if the resident is competent to sign an advance directive. The advance directive is signed by residents deemed competent in files reviewed with one stating that the resident is not competent to make a decision but that the general practitioner has made a medical decision as 'not for resuscitation'. The previous improvement required at certification is met.</p> <p>The residents and family participate in assessment, care planning and care evaluations, confirmed by residents and family interviewed.</p>
<p>Standard 1.1.13: Complaints Management</p>	FA	<p>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</p>

<p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>responding to a complaint. Complaint forms are available in the facility and family and residents interviewed know where they can get a form.</p> <p>The complaints register in place includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaints folder. The previous improvement required at certification around an up to date complaints register has been met. Two complaints were reviewed and both were responded to within timeframes documented in the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). One complaint had a letter from the complainant confirming their satisfaction with the complaints process.</p> <p>There have not been any complaints with the Health and Disability Commission (HDC) or other authorities since the last audit.</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>An open disclosure policy and procedures are in place to ensure staff maintain open communication with residents and their families. Residents' files reviewed provide evidence that communication with family members is being documented in residents' records.</p> <p>Incident forms record evidence of communication with the family following adverse events with this also documented on the communication record in each resident file and in the progress notes (refer 1.2.4).</p> <p>Residents and family members interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care.</p> <p>The facility manager and registered nurse are able to describe access to interpreting services. There are no residents currently who require interpreter services.</p> <p>The residents and family are informed of the scope of services and any items they have to pay for that is not covered by the agreement.</p> <p>Residents are provided with an information pack when they ask about the service and on entry to the service. Information about the dementia unit is verbally provided to potential residents and family.</p> <p>Information about the dementia unit is verbally provided to potential residents and family as stated by the facility manager and registered nurses interviewed. The brochure also describes the dementia unit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the</p>	<p>PA Low</p>	<p>Ohope Beach Care Limited is the governing body and is responsible for the service provided at Ohope Beach Rest Home. There is a documented strategic direction, vision, mission statement, scope of services, objectives and an action plan. The service philosophy is in an understandable form and is available to</p>

<p>organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>residents and their family / representative or other services involved in referring clients to the service. A business plan is documented and the manager provides an update around the plan through the monthly reports to the director. A current business plan is not documented.</p> <p>Ohope Beach Rest Home is managed by a non-clinical facility manager who was appointed to this position in July 2006. Two recently appointed registered nurses job share. The clinical manager has responsibility for oversight of the clinical care provided and is supporting the other registered. The clinical manager has over 10 years' experience as a registered nurse in aged care facilities that has included rest home, hospital and dementia level care. The other registered nurse has experience in acute care settings. Both the clinical manager and registered nurse have training relevant to aged care with the registered nurse enrolled in the dementia training.</p> <p>The facility manager provides a monthly report to the director. The reports include such items as occupancy, staffing, maintenance, sales and marketing, complaints, update against the business plan objectives, budgets, services, infections. The facility manager meets with the director one to two monthly to discuss the reports and any ongoing issues. The previous improvement required at certification has been met.</p> <p>Ohope Beach Rest Home can provide care for up to 36 residents with occupancy of 32 on the day of the audit.</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 Moderate</p>	<p>There is a documented quality and risk management framework. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies having been reviewed by the clinical manager in June 2015. There was a lack of review of policies at the previous certification audit and this has been met however improvements continue to be required to the content of the policies.</p> <p>There is a formal document control process in place however authorisation and/or ratification of reviewed policies is not documented. An improvement continues to be required to the document control process.</p> <p>Service delivery can be monitored through a review of complaints, incidents and accidents, surveillance of infections, review of use of restraint. Monthly reports are completed by the clinical manager on infections that includes surveillance data, skin tears and incidents and accidents. An annual report around use of restraint is documented. An internal audit programme is implemented with corrective action plans documented. There is evidence of resolution of issues in some audits reviewed. Reports include identification of any issues, documentation of data and corrective action plans documented in most cases. Improvements continue to be required to documentation corrective action plans and evidence of resolution of issues.</p> <p>The service has moved to having two meetings that include a quality meeting and staff meeting, both of which are held two monthly. The agenda items include all aspects of the quality programme however meeting minutes reviewed do not evidence robust discussion of the data presented. There are also three monthly resident meetings that keep residents informed of any changes. A family meeting is held annually with family</p>

		<p>interviewed stating that they are invited to attend and to discuss issues. Family in the dementia unit state that the meetings are held at appropriate intervals and all state that they can talk with the facility manager, clinical manager and registered nurse at any time. The previous requirement identified at certification around frequency of resident and family meetings has been addressed.</p> <p>There is an annual family and resident satisfaction survey with a high level of satisfaction documented. The results of the satisfaction survey were reported at the resident meeting in September 2015 however a full report of the feedback was not documented.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited through the internal audit programme. A health and safety representative interviewed confirmed knowledge of the role and is working with the district health board to identify any further improvements around health and safety and any changes in legislation.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA High</p>	<p>The facility manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks.</p> <p>The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process as described by care staff and the facility manager. Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>When incident forms are completed, there is evidence that these are fully completed and signed off by the registered nurse with the improvement required at certification being met.</p> <p>All accident and incident forms include documentation that confirms that the family has been advised of the adverse event. The previous improvement required has been met.</p> <p>Information gathered is regularly shared at the monthly staff meeting. Data around incidents and accidents is tabled through a monthly report and at meetings (refer 1.2.3).</p> <p>Incidents are expected to be documented on incident forms including any near misses. Each resident has a summary of incidents and any accidents in the resident file and this is expected to be updated as incidents occur. The progress notes at times documents a reference to the incident. and at times, specific and relevant observations are completed that may include neurological observations.</p> <p>Improvements continue to be required to the reporting of adverse events with the risk increased from</p>

		<p>moderate to high risk as previous requirements identified at the certification audit have been only partially met with other issues identified related to the documentation of the incidents and accidents.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in relation to human resources management. The skills and knowledge required for each position within the service is documented in job descriptions which were reviewed on staff files. The facility manager advises they have been completing criminal record vetting since May 2013 and evidence of this is reviewed on staff files for staff that have started since May 2013.</p> <p>Each staff file reviewed has an application, letter of offer, curriculum vitae and a signed contract. Job descriptions are on file in files reviewed.</p> <p>Reference checking is evident on all files reviewed and the previous requirement has been met.</p> <p>There is documented evidence that orientation has been completed on staff files reviewed. The registered nurse stated that they had not had a comprehensive orientation and the previous improvement identified at certification remains.</p> <p>Medication competencies are completed for staff apart from the facility manager. An improvement continues to be required.</p> <p>The facility manager is responsible for management of the in-service education programme and there is evidence available indicating in-service education is provided for staff once a month. The education planner for 2015 and 2016 is reviewed and provides evidence that ongoing education is provided. The attendance records indicate that there is good attendance at the sessions. Some of the key education sessions that have been provided and / or attended by all relevant staff include medicine management, cultural safety, and management of challenging behaviours. The previous improvement around attendance at training sessions and provision of training identified at certification has been met.</p> <p>The facility manager advises they are an on-site assessor for the CareerForce unit standards. All caregivers and the activities coordinator who works in the dementia unit have completed training in dementia apart from new staff members who are enrolled in the programme. Evidence of completion of the unit standards is viewed on the wall in the dementia unit.</p> <p>An appraisal schedule is in place and current staff appraisals are sighted on all staff files reviewed.</p> <p>Care staff confirm their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service</p>	<p>PA High</p>	<p>The service has a documented rationale for determining service provider levels.</p>

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>The registered nurses are on call at any time on a rostered basis with the facility manager also being able to be contacted. One registered nurse lives on site and is able to be called at any time if required.</p> <p>Care staff interviewed report there is adequate staff available and that they are able to get through their work. Residents and family state that there are sufficient staff to support them or their family member.</p> <p>All care staff working in the rest home and dementia unit are based in the dementia unit with staff supporting residents in the rest home at key intervals that includes helping residents to get up and shower in the morning, meal times and as required when call bells are rung. Staff overnight are required to complete hourly checks.</p> <p>Improvements continue to be required to staffing in the rest home with the risk increased from moderate to high risk as previous requirements identified at the certification audit have not been met. The risk has also escalated with residents requiring greater supervision at the time of the audit.</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>	<p>PA Low</p>	<p>Resident information is entered in an accurate and timely manner into a register. The facility manager confirms they are responsible for entering the resident's data into an electronic spreadsheet on the day of admission to the facility. With the exception of accident and incident forms, resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed.</p> <p>Residents' information is held securely and is not on public display. The resident's NHI number, name, and date of birth are used as the unique identifier with all documentation reviewed having a unique identifier included. The previous improvement has been met. Resident documentation includes a record of the staff members name and time of entry with designation included. The previous improvement has been met.</p> <p>Staff interviewed can describe how they maintain confidentiality of resident information. Historical records are held on site and accessible.</p> <p>An improvement continues to be required to recording of the date of entry of documentation on resident records. The risk rating remains as low.</p> <p>There is insufficient information in the resident file to ensure that there is an ability to review clinical information. Assessments and plans for activities are not necessarily held together in the resident file (refer 1.3.7).</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into</p>	<p>PA Moderate</p>	<p>The service's philosophy and mission statement is communicated to residents, family, relevant agencies and staff. The service provides information to potential referral sources. This facility operates 24 hours a day, seven days a week.</p>

<p>services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>The resident agreement includes all documentation including transportation of residents, complaints process, charges and exclusions. The previous improvement around including all aspects of the contract in the agreement has been met. All residents reviewed have signed an admission agreement however improvements are required to documentation of these.</p> <p>The residents' files reviewed include a needs assessment report that includes the level of care to be provided and needs of the resident. An improvement is required.</p> <p>Interviews with residents and family members confirm that the admission process is conducted by the facility manager and the registered nurse when they enter the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA High</p>	<p>A cupboard that is able to be locked holds the medication. The safe for the controlled drugs is in the medication cupboard. The key to the medication cupboard is held in another unlocked cupboard in the room noting that the room was locked on the days of the audit. Improvements are required to ensure that medications are able to be delivered and administered safely.</p> <p>Administration of controlled drugs is documented. Improvements are required to management of controlled drugs.</p> <p>The medication fridge temperatures are conducted and recorded. The temperatures are within range as per the policy.</p> <p>There is no evidence of transcribing and the previous improvement identified at certification has been met. There is no evidence that single use medication (saline bottles) are reused and the previous improvement identified at certification has been met.</p> <p>The residents' medicine charts lists all medications a resident is taking (including name, dose, frequency and route to be given). Each medicine prescribed is signed individually by the doctor and discontinued drugs are signed off and dated when discontinued.</p> <p>Caregivers, the registered nurse and clinical manager administer medicines. The facility manager picks up medication from the pharmacy and checks controlled drugs. Staff administering medications have an annual medication competency except for the facility manager and an improvement continues to be required. Staff education in medicine management has been provided in 2015. Two medication rounds were observed and staff administered medication as per the policy.</p> <p>Medication files reviewed have a photograph however improvements are required to identification of residents when administering medications.</p> <p>As required medication referred to as PRN medication is prescribed for residents and improvements are required.</p>

		Three monthly medicine reviews are conducted however improvements are required. Improvements are required to documentation of allergies and sensitivities.
<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>	FA	<p>An interview with the cook confirms there is a new seasonal four weekly menu that is introduced every six months. The manager states the menu was last reviewed by a dietitian in June 2013 with this reviewed. The review does not include indications that the recommendations have been addressed (refer 1.2.3).</p> <p>Food safety training for kitchen staff has been conducted.</p> <p>The cook is able to identify dietary needs with these documented on a board in the kitchen. The cook has access to dietary profiles noting that these are not up to date (refer 1.3.4).</p> <p>The resident's nutritional needs and interventions are documented on care plans sighted. Additional snacks are available for residents when the kitchen is closed and staff including staff in the dementia unit can access this.</p> <p>Each resident is weighted monthly or as changes occur. Currently the clinical staff confirm that there are no residents losing weight. Five files reviewed showed that weight for these residents was stable.</p> <p>The residents interviewed are satisfied with the food service provided. A food satisfaction survey also indicated that residents were happy with meals served.</p> <p>Fridge, chiller and freezer temperatures are recorded with temperatures within normal range. The previous improvement identified at certification is met.</p> <p>All decanted food is dated. The previous improvement identified at certification is met.</p> <p>Hats are worn in the kitchen. The previous improvement identified at certification is met.</p> <p>All food in the pantry is off the floor and there is sufficient food kept in the pantry should there be an emergency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA High	<p>The service has processes in place to seek information from a range of sources that includes family, general practitioner, specialist and referrer. Policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.</p> <p>Four of the five files reviewed did not have a needs assessment on file completed prior to the resident entering the service (refer 1.3.1). One other resident has a needs assessment on file however this was completed a month after the resident had entered the service.</p> <p>The residents' files sampled evidence residents' discharge/transfer information from the district health board</p>

		<p>(where required).</p> <p>Improvements continue to be required to the assessment process with the risk increased from moderate to high risk, as previous requirements identified at the certification audit have not been met.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Resident care plans are individualised. The residents and/or family have input into their care planning and review with the plans signed by the resident and or family indicating their involvement. Resident and family interviews confirmed that all were involved in the care planning process.</p> <p>Interventions are not well documented in resident files reviewed and an improvement continues to be required.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Staff consult with and liaise with other services to meet the needs of residents. The general practitioner states that any instructions made are followed up by staff and staff communicate any deterioration of a resident to the general practitioner in a timely manner.</p> <p>There are adequate continence and dressing supplies in accordance with needs of the residents and staff state that equipment and resources do not run out.</p> <p>Residents and family interviewed confirm their and their relatives' current care and treatments meet identified needs and all state that the service is 'excellent'. Family communication sheets record family communications and this indicates that family are kept up to date with any changes in care.</p> <p>While there are identified gaps in documentation of assessments, interventions, care planning and evaluation, there is evidence that residents are receiving services and/or interventions that are consistent with, and contribute to, meeting their described needs and desired outcomes. This is confirmed through interview with residents, family, the general practitioner and staff. The previous improvement identified at the certification audit around documentation of interventions remains.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are</p>	<p>PA Moderate</p>	<p>There are two activities staff employed at the facility. One is completing diversional therapist training.</p> <p>Staff provide an activities programme for seven hours a day, five days a week. There is one activities programme for both the rest home and the dementia residents however this is only documented for one month and it is envisaged that this will roll over each month. The programme does not include a mix of spiritual, cognitive, physical, one-to-one activities or other activities on a regular basis. It does not include any variances to the programme. Improvements to the documentation and provision of the activities programme are</p>

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>required.</p> <p>Each resident has an assessment on entry to the service around activities they like to be engaged in and an activities plan. The activities plan is documented in all files with a 24-hour plan documented for residents in the dementia unit. The plan is not reviewed at the same time as the care plan.</p> <p>Activities attendance records are maintained and are sighted.</p> <p>The residents, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. The residents meetings are now held monthly and include feedback around the activities programme. The improvement required at certification has been met.</p> <p>Improvements required to the activities programme identified at certification around 24-hour activity plans that record the required areas of challenging behaviour and appropriate activities specific to a 24 hour timeframe, an activities programme that covers sun downing period, evidence of activities provided in the weekend, documentation of an activities plan for all residents and oversight of the activities programme by a qualified person remain.</p> <p>Improvements are also required to the activities programme around a holistic activities programme, review of the activities plan at the same time as the care plan and documentation by care staff to record completion of any activities offered to residents.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>The residents' care plan evaluations are conducted by the clinical manager or registered nurse with input from the resident, family, staff and general practitioner. The family are notified of any changes in resident's condition, as confirmed in residents' files and at family interviews. The residents confirmed their participation in care plan evaluations.</p> <p>There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. The residents' files evidence referral letters to specialists and other health professional, where this has been requested.</p> <p>The activities care plan evaluations are not conducted six monthly and the previous improvement identified at certification remains.</p> <p>The improvements required at certification around care plan evaluations and the use of short term care plans identified at certification remains.</p>
<p>Standard 1.4.2: Facility</p>	<p>PA</p>	<p>A current building warrant of fitness is displayed – expiry date October 2016. There have been no building</p>

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>Moderate</p>	<p>modifications since the last audit. A grounds person is employed on a part time basis and maintenance staff and external contractors are employed as required. A book for staff to record items requiring maintenance is kept in the dementia unit and is reviewed. The facility manager and the contracted maintenance person tick the items as they are attended to.</p> <p>A planned maintenance schedule is documented and the previous improvement required at certification has been met. The splashboard behind the tubs in the main laundry that was water damaged has been replaced and the improvement required at certification has been met. A wardrobe has been installed in room 8A in the dementia unit and the improvement required at the previous certification has been met. Further areas of improvement are required to the building.</p> <p>The following equipment is available: shower chairs; a hoist and sensor alarm mats. There is an annual test and tag programme and this is up to date with checking and calibrating of clinical equipment annually. The improvement required around testing and tagging and calibration of equipment required at the certification audit has been met.</p> <p>Interviews with staff and observation of the facility confirms there is adequate equipment.</p> <p>There is a door that separates the dementia unit and the rest home that was very slow to close. This has been repaired and the previous requirement at certification has been met.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are internal courtyards and grass areas with shade, seating and outdoor tables. The dementia unit is a secure unit with a circular garden and entry/exit points into the facility from the courtyard. Most of the area is safely fenced however an improvement is required.</p> <p>Residents interviewed confirm they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>Hot water temperatures are recorded monthly and the records reviewed indicate they are at 45 degrees Celsius. The previous improvement required at certification has been met.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	<p>PA High</p>	<p>There is no indicator panel or audible indicator to alert staff who are working in the rest home area that a resident has used their call bell and improvements required at certification remain. There were also some call bells that were not operational in the dementia unit on the day of the audit. One resident has periods of wandering and staff may not be aware of any resident wandering or falling if they are not in the rest home area of the resident. An improvement is required.</p> <p>Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and</p>

<p>situations.</p>		<p>setting along with policy/procedures for visitor identification are sighted. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.</p> <p>A New Zealand Fire Service (NZFS) letter dated 12 June 2014 is sighted advising the fire evacuation scheme was approved 05 June 2005. There are six monthly trial evacuations held.</p> <p>All senior staff are required to complete first aid training and evidence of this is sighted on staff files reviewed. Staff interviews and review of staff files provides evidence of current training in relevant areas. The registered nurse has completed an advanced cardiovascular life support course. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff confirm recent education on fire, emergency and security situations. Staff records sampled provides evidence of current training regarding fire, emergency and security education. Rosters reviewed indicate that there is always a staff member with first aid training on duty and the previous requirement identified at certification has been met.</p> <p>Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.</p> <p>Information in relation to emergency and security situations is readily available/displayed for service providers and residents. There is emergency equipment that is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. Oxygen is maintained in a state of readiness for use in emergency situations.</p> <p>There is emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non-drinkable supply), blankets, and cell phones available in the event of an emergency.</p>
<p>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.</p>	<p>PA Moderate</p>	<p>The clinical manager (registered nurse) is responsible for the surveillance programme. Monthly surveillance analysis is completed with the clinical manager completing monthly infection control reports. An improvement is required to analysis of data with a process put in place to ensure that staff are aware of the data and analysis.</p> <p>Standardised definitions are used for the identification and classification of infection events, indicators or outcomes.</p> <p>There is an infection log in each resident file, progress notes documented at times and at times, short or long-term care plans updated to include the infection. An improvement is required to ensure that the infection log, progress notes and short/long term plans are aligned.</p> <p>Staff report they are made aware of any infections of individual residents by way of feedback from the clinical manager or registered nurse, through verbal handovers and progress notes.</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>Documented systems are in place to ensure the use of restraint is actively minimised and the use of least restrictive practices are encouraged where required. The Restraint Minimisation and Safe Practice (RMSP) policy definitions of enablers and restraint align with the NZS 8134.2 Standard. There are annual reviews of use of restraint and enablers. There have been no residents who have required use of a restraint or enabler since the certification audit.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	A 2014 business plan is documented and includes goals, objectives, action plan as well as core values and the management structure. The strategic direction includes a vision, mission statement, scope of services and strategic direction.	The business plan is not current.	Document an annual business plan.  180 days
Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the	PA Moderate	The clinical manager updates policies with these documented as being reviewed in June 2015. Staff state that they are informed of any review of policy and know that they are required to read these.	The previous audit identified a partial attainment around review of policies. While the policies have been reviewed, there are policies that reference evidence dated pre 2000. Documentation reviewed does not consistently provide evidence that policies and procedures are based on evidence-based rationales. This includes a lack of detail and evidence of best and evidence	Review policies and procedures to ensure that these are based on best and evidence based rationales with references documented

requirements of legislation, and are reviewed at regular intervals as defined by policy.			based practice in such policies as the wound management policy and assessment and planning policies. The improvement required at certification remains with the risk rating raised to a moderate risk.	180 days
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	<p>PA</p> <p>Moderate</p>	<p>The facility manager and clinical manager state that they are responsible for document control processes. There is a formal document control process in place.</p>	<p>There is no formal authorisation/ratification of policies and procedures once reviewed as part of the document control process.</p>	<p>Document and implement a process to ratify new or reviewed policies or procedures.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>Quality data is collected and documented in monthly reports. Reports are put up on the noticeboard in the staff room for staff to read. Minutes of the quality and staff meetings reviewed includes documentation of the data and some discussion of the data.</p> <p>There is an annual family and resident satisfaction survey with a high level of satisfaction documented.</p>	<p>Data is not analysed well. The previous requirement remains.</p> <p>Data is not communicated to staff in a meaningful way that includes discussion of the data and there is no process for staff to document that they have read and understood the implications of the data.</p> <p>A report documented re the results of the satisfaction survey was not completed.</p> <p>There is no analysis of trends.</p>	<p>Analyse data with evidence that this is used to improve service delivery.</p> <p>Communicate data to staff in a meaningful way with a process for staff to document that they have read and understood the implications of the data and any improvements</p>

				<p>required.</p> <p>Document a report on the satisfaction of residents and family as identified in the satisfaction survey.</p> <p>Analyse trends to improve service delivery.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>An action sheet template with corrective actions, by when, by whom, evaluation and sign off is sighted attached to the internal audit when issues are identified. Some of the monthly reports on aspects of the quality programme include any issues and documentation of a corrective action plan. The dietician review of the menu includes a corrective action plan. In some instances, staff sign to indicate that corrective actions have been completed.</p>	<p>Timeframes and person/s responsible for the corrective actions are not being consistently documented.</p> <p>Evidence of resolution of issues is not always evident. The previous improvements required at certification remains. The risk rating remains as a moderate.</p>	<p>Provide evidence that timeframes and person/s responsible for the corrective actions are being consistently documented.</p> <p>Document evidence of resolution of issues when these are identified.</p> <p>180 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service</p>	<p>PA High</p>	<p>Some incident forms are documented and there is evidence that some progress notes are documented following an incident. The summary logs of incidents and accidents in each file records some of the incidents. Staff describe their obligations around documenting accident / incident forms for adverse events.</p>	<p>Accident and incident forms are not always completed when an incident occurs. Evidence that an incident has occurred may be documented on the summary in each resident's file and/or in the progress notes.</p> <p>Most incidents that required neurological observations to be taken that would include</p>	<p>Ensure that an accident or incident form is always completed when an incident occurs.</p> <p>Ensure that neurological</p>

<p>shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>		<p>When documented, there is evidence that all sections are completed with the registered nurse signing the form off. The previous improvement required has been met. Opportunities to improve service delivery are included on the form in response to the incident.</p> <p>Most incidents that required neurological observations to be taken that would include an unwitnessed fall or for someone who has a head injury have these completed.</p>	<p>an unwitnessed fall or for someone who has a head injury have these completed however when documented, there is only one set of recordings taken. This does not indicate any deterioration or improvement in the resident's condition. The improvement required at certification remains.</p>	<p>observations are recorded when required that would include an unwitnessed fall or for someone who has a head injury with these taken for an extended period of time until there is evidence that the residents condition has stabilized or is stable.</p> <p>7 days</p>
<p>Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Moderate</p>	<p>Each staff member had evidence of completed orientation on file. One new staff member interviewed confirmed that there was an orientation provided that met their needs. The registered nurse stated that they had not had a comprehensive orientation.</p>	<p>The registered nurse stated that they had not had a comprehensive orientation. The improvement required at the certification audit remains.</p>	<p>Provide evidence that a registered nurse receives a robust orientation that is specific to their role.</p> <p>90 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>A 2014 training schedule is reviewed along with individual staff education records and records for each education session provided.</p> <p>Medication competencies reviewed for all staff with the exception of the facility manager who confirms that they check medications, pick up medications from the pharmacy and complete weekly stocktakes of controlled drugs when required.</p>	<p>The facility manager does not have current medication management competencies. The previous improvement required at certification remains.</p>	<p>Provide evidence that the facility manager has completed a medication management competency assessment.</p>

				30 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA High	<p>The facility manager advises that all staff are based in the care station in the dementia unit and that when residents in the rest home unit activate their call bells, staff from the dementia unit who have been allocated primary responsibility for the rest home residents go to the rest home to answer the call bell.</p> <p>Roster reviewed and indicates that the minimum staff on duty is two caregivers during the night shift and both are based in the dementia unit.</p> <p>Staff are required to complete hourly checks overnight with these documented in the resident's file. This has increased since the previous certification audit when the staff were completing two hourly checks of the residents at night.</p> <p>One resident in the rest home was identified as having increasing episodes of wandering, confusion and general deterioration of state with incident forms recorded. The doctor has documented safety concerns for the resident.</p>	<p>There is no member of staff located in the rest home 24 hours a day as they are based in the dementia unit. The improvement required at certification remains.</p>	<p>Provide a staffing solution that ensures that residents are safe and able to be monitored at all times in the rest home.</p> <p>7 days</p>
<p>Criterion 1.2.9.10</p> <p>All records pertaining to individual consumer service delivery are integrated.</p>	PA Low	<p>Resident files have been culled with minimal information included in the file. This potentially stops review of all information to make clinical decisions.</p>	<p>There are insufficient records in the resident file to allow for adequate review of clinical information.</p>	<p>Ensure that there are sufficient records in the resident file to allow for adequate review of clinical information.</p> <p>30 days</p>

<p>Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.</p>	<p>PA Low</p>	<p>Staff are consistently recording their designation when making an entry on resident's progress notes, their signature and designation on all resident forms. The previous improvement required has been met.</p>	<p>Staff are not consistently recording the date records are documented on all resident forms. The improvement required at certification remains.</p>	<p>Provide evidence that staff are consistently recording the date on all resident forms.</p> <p>30 days</p>
<p>Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	<p>PA Moderate</p>	<p>A resident agreement is signed by the resident or family member after admission to the service. The admission agreement now contains all the requirements of the DHB contract.</p>	<p>The admission agreement in the five files reviewed has been signed between four days and two months after the admission of the resident.</p> <p>Four of the five agreements reviewed included only the signed page and not the full agreement.</p> <p>Each resident file has a needs assessment report that confirms that the resident is for the level of care documented and the report identifies needs of the residents.</p>	<p>Ensure that the admission agreement in the five files is signed on the day of admission of the resident.</p> <p>Include the full signed agreement in the resident file.</p> <p>A full assessment completed by the needs assessment service is not included in the resident file.</p> <p>90 days</p>
<p>Criterion 1.3.12.1 A medicines management system is implemented to manage the safe</p>	<p>PA High</p>	<p>Medicine charts reviewed include a photograph of the resident. All medication charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. The administration of controlled drugs is</p>	<p>Controlled drugs: There is no evidence of regular weekly and six monthly stocktakes of controlled drugs. The previous improvement identified at certification remains. The registered nurse and clinical manager each have a key to the controlled drug safe and each takes it home with them when not on</p>	<p>Ensure that controlled drugs are managed, administered and checked as per best practice guidelines.</p>

<p>and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>recorded on the controlled drug register and the resident record with both signed by two staff who are medication competent. Each resident file has a photograph of the resident. Eight of ten medication files include an NHI number.</p> <p>There is a trolley that can be locked for medication and this is used to deliver and administer medication in the dementia unit. In the rest home, there is a hand held bin with a cloth to cover the medication. Improvements are required to use of secure</p>	<p>duty. The balances for two controlled drugs were checked and while one balance was correct, the other had over the amount stated in the controlled drug register (the balance of liquid medication of controlled drugs is not checked by measuring the dose) with the measurements on the bottle clearly not matching the volume of liquid. One resident was prescribed 2.5mls of morphine however on six occasions, 2mls was given.</p> <p>Identification of residents when administering medication: The photograph of the resident does not include date the photograph was taken or confirmation that the photograph is a true and correct likeness. Two of ten medication files do not record the NHI of the resident on the prescription.</p> <p>Storage of medication and accessibility of medication to the resident and authorised staff: The key to the medication cupboard is accessible to any staff in the facility. The keys to the controlled drug cupboard are not on site at all times.</p> <p>PRN medication: PRN medication does not always have what the medication is for documented. The effects of PRN medication are not always recorded in the resident record.</p>	<p>Ensure that there is a process implemented as per policy and guidelines around identification of residents when administering medication.</p> <p>Ensure that medication is only accessible to the person and the authorised staff.</p> <p>Ensure that PRN medications document what the medication is for with the effects of PRN medication recorded in the resident record.</p> <p>30 days</p>
<p>Criterion 1.3.12.3 Service providers responsible for medicine</p>	<p>PA Moderate</p>	<p>All care staff and registered nurses who administer medications have an observed competency completed with this signed off and held in the staff record.</p>	<p>The facility manager collects medication from the pharmacy and checks controlled drugs. The facility manager does not have a current medication competency. li) The</p>	<p>Ensure that any staff who administer medication have a current medication</p>

management are competent to perform the function for each stage they manage.			form used to confirm competency is signed off by the registered nurse documenting competency. The competency form does not include administration of controlled drugs or self-administration of medication.	competency. In the interim, ensure that any staff who do not have a medication competency cease administering or checking any medication. The previous improvement identified at certification remains. ii) Review the competency form to include all aspects of administration of medication.  30 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 Moderate	Allergies and sensitivities are recorded in the resident record and in eight off the ten resident medication files.  The general practitioner has documented review of a resident's medication as per timeframes documented in the resident file in six of the ten files reviewed.	Two medication files did not record allergies and/or sensitivities.  The general practitioner has not consistently reviewed each residents medication as per timeframes documented in the resident file in four of the ten files reviewed.	Ensure that medication files record allergies and/or sensitivities.  Ensure that medications are reviewed by the general practitioner as per timeframes in the resident file.  30 days
Criterion 1.3.3.1 Each stage of	PA Moderate	The policy around service delivery and documentation does not include clear processes and documentation of timeframes to	The policy around service delivery and documentation does not include clear processes and documentation of timeframes	Review and update the policy around service delivery to

<p>service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>		<p>guide staff in completion of these.</p> <p>The clinical manager is not aware of the timeframes for completion of documentation of service delivery or of the processes of assessment, care planning and review. This includes initial nursing assessments and care planning and the link to the activities assessments and plans.</p> <p>Staff are not training to complete InterRAI assessments.</p>	<p>to guide staff in completion of these.</p> <p>The clinical manager is not aware of the timeframes for completion of documentation of service delivery or of the processes of assessment, care planning and review. This includes initial nursing assessments and care planning and the link to the activities assessments and plans.</p> <p>Staff are not training to complete InterRAI assessments.</p>	<p>include processes and documentation of timeframes.</p> <p>Ensure that the registered nurses aware of the timeframes for completion of documentation of service delivery and of the processes of assessment, care planning and review.</p> <p>Provide training to registered nurses around completion of InterRAI assessments.</p> <p>90 days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>At times and for some documentation, there is evidence that service delivery is provided as per contractual specifications.</p>	<p>The service delivery is not consistently provided within specified timeframes. This was identified as a requirement at the previous certification audit and details of gaps in meeting of timeframes continues to be identified in 1.3.4, 1.3.5 and 1.3.8.</p>	<p>Provide evidence each stage of service provision is provided within specified timeframes.</p> <p>30 days</p>
<p>Criterion 1.3.4.2 The needs,</p>	<p>PA High</p>	<p>The registered nurses interviewed are aware of the need to complete an initial assessment and for re-assessment to occur six monthly or as</p>	<p>Initial assessments are not completed on entry of the resident to the service. The previous improvement required at</p>	<p>Complete initial assessments on entry of the resident</p>

<p>outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>		<p>changes occur. Challenging behavioural assessments are completed for all residents requiring this. Behavioural assessments were sighted in files reviewed and the previous improvement required has been met.</p> <p>Staff are not yet using the InterRAI assessment tool although the assessment of the resident is mostly documented as part of the care planning tool. Assessment tools including a falls assessment, nutritional assessment and assessment for risk of pressure areas was completed on entry however there have been no further assessments completed since this time in the resident file in the rest home reviewed using tracer methodology. The lack of re-assessment is seen in other files reviewed. One resident file had a needs assessment (InterRAI assessment on file.</p> <p>Improvements continue to be required to the assessment process with the risk increased from moderate to high risk as previous requirements identified at the certification audit have not been met.</p>	<p>certification remains.</p> <p>Assessment tools referred to as risk assessments at the certification audit such as pain; continence; falls; identification of risk of pressure areas; nutritional assessments are not completed in one file reviewed on admission and in four other files, they are not completed within 24-hours of admission. Assessments are not reviewed six monthly in any file reviewed. The previous improvement required at certification remains.</p> <p>InterRAI assessments are not completed.</p> <p>A holistic assessment is not completed for all residents at all times as changes occur. This includes an assessment around skin integrity and presence of pain.</p> <p>Four of the five files reviewed did not have a needs assessment on file completed prior to the resident entering the service. One other resident has a needs assessment on file however this was completed a month after the resident had entered the service.</p>	<p>to the service.</p> <p>Complete specialised assessments on admission of the resident to the service and re-assess at six monthly intervals or as required.</p> <p>Ensure that each resident has an InterRAI assessment completed.</p> <p>Complete a holistic assessment for all residents that includes skin integrity and a cultural assessment.</p> <p>Ensure that each resident has a needs assessment on file completed prior to the resident entering the service.</p> <p>90 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention</p>	<p>PA Moderate</p>	<p>Interventions relating to the assessments documented in the care plans is not identified in one resident file and is not consistently documented in four other files reviewed.</p> <p>The care plan includes interventions required</p>	<p>The required support and interventions are not consistently recorded on residents' care plans. The improvement required at certification remains.</p> <p>Interventions around management of</p>	<p>Document interventions in care plans as per needs identified in the assessment.</p>

to achieve the desired outcomes identified by the ongoing assessment process.		to manage the wound however these differ from the interventions described in the wound care plan folder in the file of the resident with dementia reviewed using tracer methodology.	wounds differs between the care plan and the wound management plan.	Ensure that interventions are consistently documented or referred to in plans consistently.  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	Interview with residents and family confirm that interventions are relevant to their needs.	There are identified gaps in documentation of assessments, interventions, care planning and evaluation and therefore it is not possible to confirm that residents are receiving services and/or interventions that are consistent with, and contribute to, meeting their described needs and desired outcomes. Improvements identified at the certification audit remain.	Provide evidence the care plan interventions are consistent with meeting residents' needs.  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 Moderate	There is an activities programme documented and displayed. The activities programme is a set one for a month, that rolls over each month. The programme indicates that movement to music is the only activity offered in the dementia unit three days a week. The programme does not include any variances that occur with a change in the entertainer over the Christmas period not recorded.  Care staff do not record any activities provided.  Two residents have an activities assessment on entry to the service around activities they like to be engaged in and an activities plan is documented in four of the five resident files reviewed. The assessment and plan are not	i) The 24-hour activity plans do not always record the required areas of challenging behaviour and appropriate activities specific to a 24-hour timeframe. The previous improvement required at certification remains.  ii) The activities programme does not cover sun-downing period and there is no evidence of care staff providing the planned activities in the weekend. The previous improvement required at certification remains.  iii) The activities staff have not completed diversional training and the activities programme has not been reviewed by a	i) Provide evidence the 24 hour activities plans detail appropriate, individualised activities to implement for residents' challenging behaviours.  ii) Provide evidence of an activities programme for sun downing period and records to support

		<p>necessarily together in the resident file.</p> <p>There is a 24-hour plan documented for residents in the dementia unit. The 24-hour activities plan now records the resident's individualised challenging behaviours, triggers and specific strategies to minimise the challenging behaviour however it does not reference timeframes over the 24-hour period. The plan is not reviewed at the same time as the care plan.</p> <p>The activities programme does not have recorded evidence of review by a diversional therapist.</p> <p>Each resident has an assessment on entry to the service around activities they like to be engaged in and an activities plan. The activities plan is documented in all files with a 24-hour plan documented for residents in the dementia unit. The plan is not reviewed at the same time as the care plan.</p>	<p>diversional therapist or other qualified person. The previous improvement required at certification remains.</p> <p>iv) The activities programme is not holistic and one to one activities and activities that include a mix of spiritual, cognitive, physical or other activities on a regular basis are not consistently documented. Residents and family interviewed state that there are an insufficient number of activities offered and a lack of a variety of activities offered particularly for residents in the dementia unit.</p> <p>v) Three resident files do not include an activities assessment and an activities plan is not documented in one of the five resident files reviewed. The assessment and plan are not necessarily together in the resident file.</p> <p>vi) The activities plan is not reviewed at the same time as the care plan.</p> <p>vii) Care staff do not record completion of any activities offered to residents in the dementia unit or rest home.</p>	<p>this is provided when activities staff are not present at the facility.</p> <p>iii) Provide evidence of trained diversional therapist for dementia residents, as per DHB contract.</p> <p>iv) Ensure that residents are offered a varied and comprehensive programme.</p> <p>v) Ensure that all residents have an assessment and plan.</p> <p>vi) Review the activities plan at the same time as the care plan.</p> <p>vii) Ensure that care staff record completion of any activities offered to residents in the dementia unit or rest home.</p> <p>90 days</p>
Criterion 1.3.8.2	PA	The residents' care plan evaluations are conducted by the clinical manager or	The activities care plan evaluations are not consistently conducted six monthly. The	Review the activities plans and reassess

<p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>Moderate</p>	<p>registered nurse with input from the resident, family, staff and general practitioner.</p> <p>The activities coordinators are responsible for completing the activities assessments and plans however an improvement identified at certification remains around evaluation of the activities plans.</p> <p>A wound assessment and wound care plan is documented with progress documented at each dressing change for one resident in the rest home whose file was reviewed using tracer methodology. The record documented at the end of each dressing does not include a full review of the wound.</p>	<p>previous improvement identified at certification remains.</p> <p>The care plan evaluations do not consistently record the degree of achievement to the interventions and support provided. The previous improvement identified at certification remains.</p> <p>The record documented at the end of each dressing does not include documentation of the size of the wound or if the wound has improved, stayed the same or deteriorated. The resident's progress notes do not consistently record management of the wound.</p>	<p>at six monthly intervals and as changes occur.</p> <p>Review the care plan at six monthly intervals and as changes occur.</p> <p>Document a full review of the wound at each dressing change and summarize progress of the wound at regular intervals.</p> <p>30 days</p>
<p>Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Moderate</p>	<p>Short-term care plans are not consistently recorded for short-term problems as sighted in two of the five files reviewed.</p>	<p>There is evidence short-term care plans are not consistently recorded for short-term problems.</p>	<p>Provide evidence of short-term care plan use for short-term problems.</p> <p>90 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>Areas for improvement to the building identified at the certification audit have been addressed.</p>	<p>Areas of improvement are required to the building including a shower unit in the dementia unit which has areas that are not able to be well cleaned; the outside area of the laundry requires cleaning; the outside area of the kitchen requires removal of rubbish; the wall behind the sluice in the laundry and other areas in the laundry have bare surfaces and are not able to be</p>	<p>Address areas in the building that require improvement.</p> <p>180 days</p>

			cleaned effectively.	
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Moderate</p>	<p>There is fencing that has been improved around the perimeter of the dementia unit however there are some areas where residents could scale existing fencing. In the past, there have been residents who have climbed over fences however care staff state that there are no residents currently who climb fences.</p>	<p>There are two areas of lattice fencing (one between the dementia unit and concrete pad outside the kitchen door and the other from a deck area in the dementia area to the concrete driveway). The fences identified are not sturdy. Potentially, residents could scale the fences.</p>	<p>Ensure that fences are safe and secure and are not able to be scaled by residents.</p> <p>30 days</p>
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>PA Moderate</p>	<p>There are three external areas in the dementia unit for residents to use. All three areas have fencing that is currently being adjusted to minimise the risk of residents climbing over the fence and absconding. The facility manager advises they have at least one resident who is a 'climber' and who has climbed over the fencing. Visual inspection indicates that the majority of the fencing is trellising and the fences are having their height extended by adding soft wire mess type fence above the trellising. The facility manager advises that residents are supervised whenever they are in any of the outside areas</p>	<p>The fences in the three external areas in the dementia unit are potentially able to be climbed over by residents. It is acknowledged the facility manager is aware of this issue and is attempting to address it.</p>	<p>Provide confirmation that the external areas in the dementia unit are safe and residents are not able to climb over the fences.</p> <p>90 days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA High</p>	<p>The facility manager and staff interviewed confirm that all staff are based in the care station in the dementia unit apart from at specific hours in the morning and afternoon when staff support residents to get up, at meal times and when there are set activities in place. Staff are alerted to any rest home</p>	<p>There is no indicator panel or audible indicator to alert staff who are working in the rest home area that a resident has used their call bell. The previous improvement required at certification remains. ii) Two bedrooms in the dementia unit do not have a mechanism whereby staff can be called.</p>	<p>Provide confirmation that staff working within the rest home are alerted, and respond in a timely manner, when a resident within the</p>

		<p>resident needs when the resident or another resident/facility member activates the call bell. This alerts staff in the dementia unit to answer the call bell. When rung, the call bell in the rest home is not able to be heard or seen on a panel. Staff in the dementia wing carry a cell phone and if there is a second rest home call bell rung when the staff member is already in the rest home, the staff member will ring the staff member already in the rest home and inform them of a second call bell ringing.</p> <p>Four rooms in the dementia unit do not either have a call bell or the call bell is not working. On the second day of the audit, the electrician was in the building fixing call bells.</p> <p>Rest home residents interviewed report that staff respond to the call bells in a timely manner.</p> <p>One resident has had significant episodes of confusion and wandering with periods of lucidness. There is a note on the resident file regarding the concern around safety for the resident given the 'decrease in staffing'. Staff complete hourly checks of the rest home when staff are stationed in the dementia unit.</p>	<p>One bedroom and one bathroom has a call bell port but these were not operational on the day of the audit. iii) Staff cannot confirm that they would be aware of a resident who was confused who wandered out of the building or had a fall in the hour when they are not in the rest home. The previous requirement around call bells identified at certification however the risk rating has escalated from low to high given the acuity of residents in the rest home currently.</p>	<p>rest home activates their call bell.ii) Implement a process that checks to see that call bells are operational at all times. Iii) Ensure that there is a safe environment for residents with staff able to be alert to any changes in state of a resident.</p> <p>7 days</p>
<p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the</p>	<p>PA</p> <p>Moderate</p>	<p>The clinical manager completes monthly infection control reports. These detail the number of infections however there is little discussion of how the data could be used to improve service delivery. The reports are put up on the notice board in the staff room and staff are expected to read these. There is no process to confirm that staff have read the information.</p>	<p>The data and information on the infection log, progress notes and short-term plans and/or long-term plans does not align. ii) There is limited analysis of the infection control data and no evidence of the data used to improve service delivery. iii) There is no process to confirm that staff have read the infection control reports.</p>	<p>i) Ensure that the data and information on the infection log, progress notes and short-term plans and/or long-term plans align. ii) Analysis the</p>

<p>frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>		<p>There are a significant number of urinary tract infections documented. The general practitioner interviewed was able to provide a rationale around the high number however this was not recorded in the reports and while the general practitioner is implementing resident based interventions to address the infection, there is no trend analysis or use of the data to improve service delivery overall.</p> <p>There is an infection log in each resident file. Progress notes include reference to any infection at times and at times the infection is documented on a short term care plan. An improvement is required to ensure that the infection log, progress notes and short-term plans are aligned.</p>		<p>infection control data and trends with evidence of the data used to improve service delivery. iii) Implement a process to confirm that staff have read the infection control reports.</p> <p>90 days</p>
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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.