

# St Allisa Rest Home (2010) Limited - St Allisa Lifecare

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## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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>	St Allisa Rest Home (2010) Limited
<b>Premises audited:</b>	St Allisa Lifecare
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
<b>Dates of audit:</b>	Start date: 9 February 2016      End date: 10 February 2016
<b>Proposed changes to current services (if any):</b>	The audit included verifying as appropriate to provide 'medical level care' as part of their hospital services certification
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	85

# 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

St Allisa rest home is one of 21 facilities owned by the Arvida group. The manager has been in the role under the new ownership since December 2014, having previously been the owner/manager of St Allisa rest home. The service is certified to provide rest home, hospital (geriatric), physical disability and dementia level care for up to 109 residents. There were 85 residents at St Allisa Rest home on the days of audit. Two wings of the facility are currently closed and undergoing refurbishment.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. 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 general practitioner.

This audit also verified the services appropriateness to be certified for 'medical level care' under their current hospitals certification.

The manager works full time and is supported by a clinical manager and a part time quality manager. Residents, families and general practitioner interviewed commented positively on the care and services provided to residents at St Allisa Rest home.

The certification audit identified that improvements are required around advance directives, incident reporting, training, registered nurse sign off of care plans, timeframes for completion of documentation, progress notes entries, care plan interventions, medication documentation, and hot water temperatures.

## 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.
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St Allisa rest home provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Residents and family interviewed verified on-going involvement with community. Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code.

## 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 low risk.
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St Allisa rest home is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Entry to the service is managed primarily by the nurse manager or clinical manager. There is comprehensive service information available. Initial assessments are completed by a registered nurse. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. The documented activities programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided.

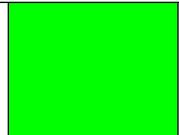
## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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There is a current building warrant of fitness which expires on 1 March 2016. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There are a lounge and dining areas in both the upstairs and downstairs areas and in the dementia unit. There are also small seating areas throughout the facility. Furniture is appropriate to the setting and arranged in a way that allows residents to mobilise.

There is a designated laundry which includes storage of cleaning and laundry chemicals. Chemicals are stored in a locked storage cupboard. The service has implemented policies and procedures for civil defence and other emergencies. Alternative power and cooking facilities are available in the event of a power failure. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided.

## 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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There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There is currently one resident requiring restraint and two residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

## 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.

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	42	0	6	2	0	0
<b>Criteria</b>	0	92	0	7	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>St Allisa rest home has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Twelve caregivers, three diversional therapists and five registered nurses (RN) were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with nine residents (five rest home and four hospital).</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Low	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately but do not clearly guide staff in relation to resuscitation status. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p>

		Ten of ten resident files sampled (two from the rest home, four from the dementia unit and four from the hospital) had signed consents.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with residents and family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. Advocacy is discussed at resident meetings and information is available along with complaints forms and process.</p> <p>Residents confirm that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the residents' family and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Interview with residents confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs and interest groups in the community. Residents confirm the staff help them access community groups.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice which aligns with Right 10 of the Code. The manager leads the investigation of concerns/complaints. Complaints forms are visible and available for relatives/residents. A complaints procedure is provided to residents within the information pack at entry. The service has received two complaints in the past year and these have been appropriately managed. The complaints register is up to date. Management operate an "open door" policy.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health &amp; Disability (HDC) Commission. Relatives and residents are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement – where signed (link #1.3.1.1). Residents and five family members (two hospital and three dementia) interviewed confirmed they received all the relevant information during admission.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents interviewed confirmed staff respect their privacy, and support residents in making choice where able. Staff have completed education around privacy, dignity and elder protection.</p> <p>Resident files are stored securely. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>St Allisa rest home has a Maori health plan and a cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Residents who identify as Maori have this documented in their files and care plans include interventions to meet their cultural needs. Linkages with Maori community groups are available and accessed as required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the residents needs are being met. Discussion with family and residents confirm values and beliefs are considered. Residents are supported to attend church services of their choice.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the nine staff files sampled. Staff comply with confidentiality and the code of conduct. The RN's and allied health professionals practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the manager, the registered nurse and care staff confirmed an awareness of professional boundaries. Registered nurse files reviewed evidence attendance as professional boundaries and code of conduct training.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>St Allisa rest home policies and procedures meet the health and disability sector standards. Staff state they are made aware of new/reviewed policies and sign to say they have read them. An environment of open discussion is promoted. Staff report the manager and registered nurses are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The RN's has access to external training. Discussions with residents and family were positive about the care they receive.</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>There is a policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The manager and clinical manager confirm that family are kept informed. Relatives stated they are notified promptly of any incidents/accidents. Families receive newsletters that keep them informed on facility matters and events. Resident meetings encourage open discussion around the services provided (meeting minutes sighted).</p> <p>There is access to an interpreter service as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>St Allisa rest home provides care for up to 109 rest home, hospital (including medical), physical disability, and dementia level care residents. On the day of audit there were 85 residents which included 38 rest home, 27 hospital and 20 residents in the dementia unit. There were 11 younger persons under long term chronic health condition contracts (seven rest home and four hospital). There were no respite residents. The service has two wings (24 beds) of the facility under going refurbishment which are closed to residents and staff.</p> <p>The service has a business plan which is reviewed annually. The business plan identifies the purpose, values and scope of the business. The service has quality goals which are reviewed at the quality management meetings. The Arvida group purchased St Allisa rest home in December 2014. The manager was the previous owner/manager of the service. The manager is a registered nurse and is supported by a clinical manager, and a quality manager. The clinical manager has been in the role since October 2015.</p> <p>This audit also verified the services appropriateness to be certified for</p>

		<p>'medical level care' under their current hospitals certification.</p> <p>The manager has completed at least eight hours of professional development including regional provider meetings, and a managers training day.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager provides cover in the absence of the manager as required.</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>	FA	<p>St Allisa rest home is implementing a quality and risk management system. The quality manager and manager oversee the quality programme. The quality programme includes goals for 2016. The previous year's plan has been reviewed.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies. Assessment policies have been updated to include reference to the use of the InterRAI assessment tool.</p> <p>Monthly quality meeting minutes sighted evidence of discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons, trends and graphs are displayed for staff information. The care staff interviewed were aware of quality data results, trends and corrective actions.</p> <p>Annual resident and relative surveys are conducted with excellent results achieved for 2015. Results have been collated.</p> <p>There is an internal audit programme that covers all aspects of the service. A summary of internal audit outcomes is provided to staff. Corrective actions have been developed and implemented for shortfalls in service identified. The service continues to work on continuous improvements aiming at improving resident outcomes.</p> <p>There is an implemented health and safety and risk management system</p>

		<p>in place including policies to guide practice. There is a current hazard register. Staff confirm they are kept informed on health and safety matters at meetings. The two areas currently undergoing building work are sealed off from staff and residents.</p> <p>Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>A sample of accident/incident forms for the months of December 2015 and January 2016 were reviewed. There has been RN notification and clinical assessment completed within a timely manner. Accidents/incidents were also recorded in the resident progress notes. There is documented evidence the family had been notified promptly of accidents/incidents. Not all incidents identified have been documented on an incident report.</p> <p>The service collects incident and accident data and reports aggregated figures to the quality meeting and the health and safety meeting. Staff interviewed confirm incident and accident data are discussed at the staff meeting and information and graphs are made available.</p> <p>Discussions with the manager confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies to support recruitment practices. Nine staff files sampled contained all relevant employment documentation and included the clinical manager, one diversional therapist, one cook, three registered nurses and three caregivers. Current practising certificate was sighted for all registered nurses and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>There is an education planner in place for 2016. Six (of 13) registered nurses have completed InterRAI training. Clinical staff complete competencies relevant to their role. Not all educational requirements have been provided over the past two years.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager and clinical manager are on-site full time and available after hours. The registered nurses are rostered on 24/7 and provide cover for residents in the dementia unit. The caregivers, residents and family interviewed inform there are sufficient staff on duty at all times.</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>	FA	<p>The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information is kept confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Files are integrated.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The nurse manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical co-ordinator. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement (link 1.1.10.4). The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</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 Moderate</p>	<p>The medication management policies and procedures except standing orders comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed is not always signed as administered on the pharmacy generated signing chart. All staff that administer medication are competent and have received medication management training. The facility uses a blister pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medication charts are written by medical practitioners and there was evidence of three monthly reviews by the GP. Indications for use for as required medications are not always documented. Not all medication charts sampled have correct indications for use documented for as required medications. One resident has a medication prescribed incorrectly as both regular and as required. Four residents self-administer medicines and all have a current competency assessment.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a fully functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. The kitchen is able to meet the needs of residents who need special diets and the cook works closely with the RNs on duty. The kitchen staff have completed food safety training through ACE. The cooks follow a rotating seasonal menu which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this decision to residents/family/whanau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed and assessments were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. The InterRAI assessment tool is implemented. Care plans are developed on the basis of these assessments with exceptions (link 1.3.5.2).</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>Identified needs were not always addressed in care plans sampled. Long term care plans reviewed did not all fully describe the support required to meet the resident's goals and needs. All identified allied health involvement under a comprehensive range of template headings. Residents and their family/whanau are involved in the care planning and review process. Short term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.</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 Low</p>	<p>Interviews with registered nurses, clinical manager and caregivers demonstrated an understanding of the individualised needs of residents and report that two hourly turns occur. Food and fluid charts are comprehensively completed as required. Turning charts sighted indicated documented gaps. Ongoing pain is not always documented as assessed and pain monitoring charts are not in use. If external nursing or allied health advice is required the RNs will initiate a referral (e.g. to the district nurse). If external medical advice is required this will be actioned by the GP. Staff have access to sufficient medical supplies (e.g. dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Wound monitoring and wound management plans are in place for 12 wounds including two pressure areas (link 1.3.3). All of these wounds have comprehensive assessments but the grade is not documented for the two pressure injuries. The RNs have access to specialist nursing wound care management advice through the district nursing service.</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 appropriate to their needs,</p>	<p>FA</p>	<p>Four diversional therapists are employed to operate the activities programme for all residents over seven days. Caregivers also provide activities in the dementia unit. Each resident has an individual activities</p>

<p>age, culture, and the setting of the service.</p>		<p>assessment on admission and from this information an individual activities plan is developed as part of the care plan by the diversional therapists. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. There is a separate programme for the dementia unit and one for the rest home/hospital. Group activities reflect ordinary patterns of life and include planned visits to the community. Activities to meet the needs of younger residents are provided. All long term resident files sampled have a recent activities plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Plans sampled in the dementia unit document activities to support the resident over the 24 hour period. Residents and families interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans are evaluated by the registered nurses within three weeks of admission. The long term care plan is evaluated at least six monthly or earlier if there is a change in health status. Behaviour risk management plans have not been reviewed regularly (link 1.3.3.3). There is at least a three monthly review by the GP. Changes in health status are documented (link 1.3.5.2). Care plan reviews are signed by an RN. Resident files sampled demonstrate that short term care plans are evaluated and resolved or added to the long term care plan if the problem is on-going. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Interviews and medical notes demonstrate that referrals and options for care were discussed with the family. The staff provided examples of where a resident's condition had changed and the resident was reassessed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous</p>	<p>FA</p>	<p>There are policies and procedures in place for waste management. Residents, staff and visitors are protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and chemicals are stored</p>

<p>substances, generated during service delivery.</p>		<p>securely. Laundry and sluice rooms are locked when not in use. Product use information is available. Protective equipment including gloves, aprons, and goggles are available for use by staff. Staff interviewed were familiar with accepted waste management principles and practice.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The facility is two storied. It has a current building warrant of fitness, which expires on 1 March 2016. The maintenance person works full time and completes annual scheduled maintenance. Staff also alert him to issues that require attention. Assessment for hot water temperatures checks are conducted monthly. Hot water is not always provided at 45 degrees maximum in resident areas. Medical equipment including scales and hoists have been checked and calibrated annually. Electrical equipment has been tested. The upstairs floor area can be accessed by two flights of stairs and a lift.</p> <p>There is a small internal seating area at the entrance available for residents and visitors. Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors. The exterior by the entrance is well maintained with safe paving, outdoor shaded seating, lawn and gardens and car parking. Interviews with the registered nurses and the caregivers confirmed that there was adequate equipment to carry out the cares according to the resident's care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All resident rooms have full ensuite facilities. There are large communal lounge and dining areas both upstairs and downstairs for rest home and hospital residents. There is a dining room and lounge area in the dementia unit. Dementia residents have access to a secure outdoor garden area with gardens, paving and natural shade. All rooms have full ensuite facilities. There are also sufficient communal toilets adjacent to the lounge and dining areas. Two wings are currently closed for refurbishment (24 beds). The number of visitor and resident communal toilets provided is adequate. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use</p>

		signs.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	The rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. Bedrooms are personalised.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Here is a large lounge and dining room on both floors and small seating areas which are used for activities, recreation and dining activities. The dining room downstairs is spacious, and located directly off the kitchen/servery area. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed report they can move around the facility and staff assist them if required.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the designated laundry staff. Staff attend infection prevention and control education and there is appropriate protective clothing available. Cleaners are employed seven days a week. Manufacturer's safety data charts are available for reference if needed in an emergency. Residents and family interviewed report satisfaction with the laundry service and cleanliness of the facility.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	The service has a fire and emergency procedures manual. The evacuation scheme was approved by New Zealand Fire Service on 2 May 2013. The last fire drill was conducted on 15 December 2015. There is a staff member (registered nurse) with a first aid certificate on each shift. Fire safety training has been provided. There is an electronic call bell system in place. A civil defence kit is stocked and checked monthly. Water is stored, sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. There are emergency management plans

		in place to ensure health, civil defence and other emergencies are included.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	All communal and resident bedrooms have external windows with plenty of natural sunlight. The facility is heated by a mix of wall panels and heat pumps (all of which are electric). Windows and ranch sliders open for ventilation. The general living areas and resident rooms were appropriately heated and ventilated on the day of audit. Residents and family interviewed state the environment is comfortable.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	St Allisa has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The quality manager (a registered nurse) is the designated infection control coordinator with support from the nurse manager, the clinical manager and the infection control team. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The quality manager at St Allisa is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the on-going education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed significant infection control training and has previously contracted to an infection control specialist organisation. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections for each area based on signs and symptoms of infection. Short term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at all meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse manager and clinical manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimized. There was one resident with restraint and two residents with an enabler. Enabler use is voluntary. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Recently updated policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP /enablers has been provided. Restraint has been discussed as part of quality meetings. The clinical manager is the designated restraint coordinator.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers</p>	<p>FA</p>	<p>The clinical manager is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.</p>

and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the one restraint and two enabler files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed assessments and consents were fully completed.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/ met. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms document regular monitoring at the frequency determined by the risk level. Evaluations are completed. The service has a restraint and enablers register which is up to date.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	For residents requiring restraint a complete new restraint assessment is completed every six months as part of the evaluation and restraint use is reviewed in meetings.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly quality meetings.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	PA Low	<p>Two of nine resident files sampled (from the rest home) contained an advance directive that documented that the resident had signed the document of their own free will and the GP had countersigned that the resident was competent. The content of what the resident was signing for (including whether or not they wished to be resuscitated) was unclear. The other eight resident files sampled (four from the dementia unit and four from the hospital) had a signature from the GP confirming that the resident was not competent to make an advance directive but did not document resuscitation status. The policy did not clearly guide staff around when no</p>	<p>Advance directive forms reviewed did not all clearly document the resuscitation status and the policy did not clearly guide this.</p>	<p>Ensure policy and advance directives clearly guide staff around the resuscitation status of each resident.</p> <p>90 days</p>

		advance directive was made.		
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Following review of resident incidents and accidents and associated resident files, it was identified that one of two pressure injuries had been reported via the incident reporting process. One bruise (as identified through review of progress notes had not been reported. The incident and accident forms reviewed included falls, skin tears, and challenging behaviours.</p>	<p>One resident with a recent stage II pressure injury (now healed) and one resident with a bruise, had not had these incidents reported via the incident reporting process.</p>	<p>Ensure that all incidents and accidents are reported via the incident reporting process.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>The education programme for the past two years was reviewed, including attendance rates. Registered nurses and senior caregivers complete annual medication competencies. Registered nurses complete syringe driver training and competencies. In 2015, education has been provided around fire training, palliative care, infection control falls prevention, medication management and challenging behaviour. Attendance records are maintained. The cook has completed safe food handling through module 8 in the ACE programme.</p>	<p>Wound care, skin management, pressure area prevention and cultural safety training has not been provided in the past two years, (noting this is scheduled in 2016)</p>	<p>Ensure that all educational requirements are provided</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing,</p>	PA Moderate	<p>Registered nurses and caregivers who have been assessed as competent administer medications. Not all prescribed medications have been signed as administered. Standing orders are signed by the two regular</p>	<p>(i) The standing orders do not meet the requirements of the medication guidelines.</p> <p>(ii) Seven of 20 medication records sampled had regular medications</p>	<p>(i) Ensure standing orders meet requirements.</p> <p>(ii) Ensure medications are administered as</p>

administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		GP's. They do not meet the medicine care guidelines. Medications are prescribed by GP's and are reviewed at least three monthly. Indications for use for as required medications are not always documented and one chart sampled had a prescribing error, noting that the medication had been administered appropriately.	that had not all been signed for as administered.  (iii) Eleven of twenty medication charts sampled have as required medications prescribed with no indication for use documented.	prescribed.  (iii) Ensure indications for use are documented for as required medications.  30 days
<p>Criterion 1.3.3.1</p> <p>Each stage of 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>	PA Low	<p>The care plans sampled in the hospital and rest home were completed by the registered nurses with diversional therapists having completed the social and activities sections. In the dementia unit the diversional therapist had completed behaviour risk management plans and reviewed by a registered nurse.</p> <p>The registered nurses interviewed report that they sight all residents in the dementia unit at least daily and address all needs as these are reported. Regular registered nurse input was not documented in progress notes in the four dementia unit files sampled. One rest home resident file had issues documented by caregivers with no registered nurse follow up.</p>	<p>(i) Four of four dementia resident files sampled did not have evidence of ongoing registered nurse input documented in progress notes.</p> <p>(iii) One of two rest home resident files sampled had issues identified by caregivers in progress notes on two occasions with no documented registered nurse follow up.</p>	<p>(i) Ensure that residents with dementia are reviewed and assessed regularly by a registered nurse and that this is documented.</p> <p>(iii) Ensure that registered nurses follow up all identified issues and that this is documented.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and</p>	PA Low	All resident files sampled for residents admitted in 2015 had initial assessments available that had been completed within 24 hours of admission. The three residents admitted since 1	(i) Two of ten residents files sampled (one hospital and one dementia) where the resident had been admitted since 1 July 2015 did not have an interRAI assessment	(I) Ensure all new residents have an interRAI assessment completed within 21

<p>exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>July 2015 had an interRAI assessment completed, but these had not been completed within 21 days of admission. All resident files sampled had a current interRAI assessment in the file.</p> <p>Progress notes are written most days in all ten files sampled.</p>	<p>completed within 21 days of admission.</p> <p>(ii) Three of four hospital resident files sampled did not have a progress note documented at least every 24 hours.</p> <p>(iii) Two of two behaviour risk management plans for residents in the dementia unit had not been documented as reviewed, [one for four years], however the RNs stated these have been reviewed as part of the care plan review process and did not require amendments.</p>	<p>days of admission.</p> <p>(ii) Ensure that progress notes are documented at least every 24 hours for hospital residents.</p> <p>(iii) Ensure all care plans/behaviour plans are documented as reviewed by a registered nurse at least six monthly</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>All resident files had a long term care plan completed using a templated document. Four of the ten files long term care plans reviewed described the support required to meet the resident's goals and needs.</p>	<p>Six of ten care plans sampled did not include interventions for all identified needs.</p>	<p>Ensure care plans document interventions for all identified needs.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Three of the four hospital resident files sampled had the need for regular turns to minimise the risk of pressure injuries documented in the care plan. Two of these residents had turning charts that did not consistently document regular turns and the other did not have turns documented. The caregivers and registered nurses interviewed report residents are turned regularly. All wounds (12 in total) had a comprehensive assessment and</p>	<p>(i) Two current pressure injuries do not have the grade documented.</p> <p>(ii) Two hospital resident files sampled with identified pain did not have regular pain monitoring recorded (noting the pain has now been addressed and resolved for one of these residents).</p> <p>(iii) Three hospital resident files sampled require regular turning. One did not have turns documented</p>	<p>(i) Ensure the grade is documented for all pressure injuries.</p> <p>(ii) Ensure regular pain monitoring occurs for residents with pain.</p> <p>(iii) Ensure regular turns are documented as completed when these are required.</p>

		<p>management plan documented but the assessment did not include documenting the grade for two pressure injuries (the grade could be determined by the assessment provided). Timeframes for review were documented in a diary. Two of the resident files sampled had ongoing pain recently although this had resolved for one resident. Neither had ongoing pain monitoring documented. Weights are intended to be measured and recorded at least monthly for all residents. The registered nurses interviewed reported that this is undertaken by caregivers and reported to the registered nurse when there is a fluctuation. The one resident file sampled where weight loss had been identified had received appropriate referrals and interventions around this.</p>	<p>and the other two did not have regular turns consistently documented. However caregivers interviewed described their turning regime.</p>	<p>60 days</p>
<p>Criterion 1.4.2.4 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 Low</p>	<p>Hot water temperature monitoring is conducted monthly at various areas around the facility including the kitchen, laundry and resident rooms. Hot water records for the months of January and February 2016 were reviewed and extended to assess recordings for the last six months of 2015. Hot water temperatures have been over the limit of 45 degrees Celsius on a number of occasions. The service was aware of this issue and had one hot water cylinder thermostat replaced. A contracted plumber has also attended and is working to solve the problems</p>	<p>Hot water temperatures in resident areas were over the acceptable limit (between 46 – 50 degrees) in the rest home and hospital wings in January, and in all wings in February 2016. Noting the service has been working with a plumber and managing the risk around the temperatures and therefore the risk has been identified as low</p>	<p>Ensure that hot water provided in resident areas does not exceed the limit of 45 degrees Celsius.</p> <p>60 days</p>

		however, the issue has not been rectified.		
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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.

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End of the report.