# Capital Residential Care Limited - Ocean View Residential Care

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Capital Residential Care Limited

**Premises audited:** Ocean View Residential Care

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 4 April 2016 End date: 4 April 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 18

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Ocean View is owned and operated by Capital Residential Care Limited and cares for up to 20 residents requiring rest home level care. On the day of the audit, there were 18 residents.

The service is overseen by a facility manager, who is a registered nurse with management experience in community based services and aged care services. The facility manager has been in the role for twelve months and is supported by a clinical nurse manager (RN) with many years aged care experience, who has been in the role for fourteen months.

Residents and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

This audit has identified the following areas requiring improvement; management of cultural safety, policies and procedures, internal audits, corrective action plans and meetings, management of risks, job descriptions, staff training, performance appraisals, the admission agreement, falls management, testing and tagging of the chair lift, maintenance and annual review of the infection control programme.

## Consumer rights

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

Staff at Ocean View strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Policies are implemented to support residents’ rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## 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. |

The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are planned to generate improvements in practice and service delivery. Residents/family meetings have been held and residents and families are surveyed annually. There are Health and safety policies documented to manage risk. Incidents and accidents are reported and followed through. An education and training programme has been developed with a current training plan in place. There are documented employment processes. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## 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. |

There is a comprehensive admission package available prior to or on entry to the service. Resident records reviewed provide evidence that the registered nurses utilise the InterRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six monthly. Resident files include three monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner/nurse practitioner.

An integrated activities programme is implemented for all residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on site. All residents' nutritional needs are identified and documented on admission.

## Safe and appropriate environment

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

Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness, which expires 2 June 2016. Resident rooms are single, spacious and personalised. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant. All hoists have been serviced and calibrated. Hot water temperatures are monitored.

## 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. |

Ocean View has restraint minimisation and safe practice policies and procedures in place. On the day of audit, there was one resident with two restraints and no residents using an enabler. Restraint management processes are adhered to.

## 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 low risk. |

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 as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 43 | 0 | 4 | 3 | 0 | 0 |
| **Criteria** | 0 | 90 | 0 | 6 | 5 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (two caregivers, one activities coordinator, one clinical nurse manager (RN), one registered nurse and one facility manager) confirm their familiarity with the Code. Interviews with five residents and three families confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Five resident files sampled demonstrated that advanced directives are signed-for separately. There is evidence of discussion with family/whānau when the GP has completed a clinically indicated not for resuscitation order. Caregivers and the registered nurse interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative’s lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents signed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff have not received training on advocacy in past two years (link 1.2.7.5). Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to be involved in community activities and maintain their family/whānau and friend’s networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that family/whānau visiting could occur at any time. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaints register. Verbal and written complaints are documented. There have been four documented complaints since May 2014. All complaint documentation was reviewed. All complaints had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the facility manager discusses the information pack with the resident and the family/whānau. The information pack incudes a copy of the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are policies in place to guide practice in respect of independence, privacy and respect. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms during the audit. The residents interviewed confirmed staff respect their privacy, and support residents in making choice where able. Resident files are stored securely.  The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family/whānau involvement.  The service actively encourages residents to have choices and this includes voluntary participation in daily activities.  Five resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified on admission and integrated with the residents' care plan. Interviews with residents confirm their values and beliefs are considered. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | PA Low | Ocean View does not have a documented Māori health plan that includes a description of how staff will achieve the requirements set out in A3.1 (a) to (e) of the ARRC contract.  A cultural and spiritual awareness policy is documented to guide practice but this does not include recognition of Māori values and beliefs and does not identify culturally safe practices for Māori. The staff member who acted as the cultural advisor has recently left the organisation and this role had not been replaced at the time of audit. Staff interviewed were unable to describe their links to local Iwi or how they would ensure Māori values and beliefs are met. Staff have not had training in Cultural Safety in the past two years (link 1.2.7.5).  Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. At the time of audit, two residents identified as Māori. The resident’s values and beliefs were not documented in the care plan. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The resident and family are invited to be involved in care planning. Not all residents had their beliefs or values incorporated into the care plan (link 1.1.4.3). Six monthly reviews occur to assess if needs are being met. Discussion with relatives and residents confirm values and beliefs are considered. Residents are supported to attend church services of their choice. Spiritual visitors spend time with residents who wish to have prayers/bible readings. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The clinical nurse manager and registered nurse supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice. However not all the required polices were documented or, where documented, the policies did not all align with the health and disability services standards, for residents with aged care needs or legislative requirements (link 1.1.4.3. and 1.2.3.3). There is an education planner in place (link 1.2.7.5). There are handovers between shifts. Registered nurse care guidelines are available. Allied health professionals are available to provide input into resident care for example dietitian and podiatrist.  There are implemented competencies for caregivers and registered nurses. The clinical nurse manager and facility manager have access to external training. Discussions with residents and family were positive about the care they receive. Interview with caregivers informed they are well supported by the clinical nurse manager and facility manager who are available after hours.  Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents interviewed spoke positively about the care and support provided. Staff interviewed had a good understanding of the principles of aged care and stated that they feel supported by the management team. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/whānau of any accident/incident and ensure full and frank open disclosure occurs. Seven incidents/accidents forms were reviewed. The forms included a section to record family/whānau notification. All forms indicated family/whānau were informed or if family/whānau did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member’s health status. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Ocean View is owned and operated by Capital Residential Care Limited. The service provides rest home care for up to 20 residents. On the day of the audit, there were 18 rest home level care residents. This includes one resident admitted under Accident Compensation Corporation (ACC).  The facility manager is a registered nurse who maintains an annual practicing certificate. The facility manager has been in the role for twelve months and advised on the day of audit that this was their last week in the role. No information was available regarding filling the vacant position.  The facility manager reports to the owners of the company weekly on a variety of operational issues. A clinical nurse manager with seven years aged care experience in New Zealand has been at the facility for fourteen months. The facility manager and the clinical nurse manager have completed in excess of eight hours of professional development in the past 12 months.  Ocean View has a 2016-2017 strategic business plan that includes the home mission statement and philosophy of care. Annual goals relate to residents, staff, quality assurance, risk management and financial goals. The business plan is reviewed each year in August. |
| Standard 1.2.2: Service Management  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. | FA | In the absence of the facility manager, the clinical nurse manager is in charge with support from the owners and care staff. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | Ocean View has a business/strategic plan that includes quality goals. There is an internal audit programme, however not all scheduled monitoring has been completed. Corrective actions are not always documented where internal audits identify opportunities for improvements and the facility manager does not always sign off corrective action plans.  The quality and risk management programmes includes an internal audit programme and data collection, analyses and review of adverse events including accidents, incidents, infections, wounds and complaints.  The service does not have a documented meeting schedule however, the facility manager advised that bi-monthly staff and resident meetings are required. Quality/staff and resident meetings have not consistently been held. Audit findings and information about corrective actions has not always been communicated to the staff.  Restraint and enabler use is an agenda item at the quality/staff meetings.  Residents are surveyed to gather feedback on the service provided however, the outcome of the 2016 resident satisfaction survey was not communicated to staff. The 2016 resident survey indicated satisfaction with the service.  There is a Health and Safety and risk management system in place including policies to guide practice. There is a current hazard register, which was last reviewed in March 2016. Not all hazards are documented on the register and not all hazards have interventions documented to manage the risk.  Falls prevention strategies are in place (link 1.3.6.1). |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an accidents and incidents reporting policy. The clinical manager investigates accidents, and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality/staff meetings. The clinical manager conducts clinical follow-up of residents. Seven incident forms sampled (from a sample of resident files) demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks be completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed (clinical nurse manager, one enrolled nurse, two caregivers, one cook and one activities officer) and evidence that reference checks were completed before employment was included. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There was no education planner available for 2015 to 2016. The in-service education programme for 2016 has been documented and implemented. However not all education required under the ARRC agreement has been delivered in the past two years. The facility manager and clinical nurse manager are able to attend external training, including sessions provided by the local DHB. The clinical nurse manager and facility manager have completed InterRAI training. Annual staff appraisals and job descriptions were not all evident in all the staff files reviewed. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Ocean View has a policy for staff rationale. An enrolled nurse and clinical nurse manager (RN) are rostered on Monday to Friday and the facility manager and clinical manager share after hours call. There are two staff on morning and afternoon shift and one on overnight, in addition to the management team.  The facility manager and the clinical manager cover the on call and provide cover for each other for periods of leave. The after-hours medical centre also provides back up for RN cover in times of sickness or emergencies. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregiver, enrolled nurse or clinical manager. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | PA Low | There are policies and procedures to guide entry to services, including a comprehensive admission policy. Information gathered on admission is retained in residents’ records. Relatives interviewed stated they were well informed upon admission. The service has an information pack available for residents/families/EPOA at entry. The admission agreement reviewed does not align with the Aged Related Residential Care (ARRC) agreement; however, the five admission agreements viewed were signed. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge, was well documented in progress notes. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The clinical nurse manager and facility manager checks all medications on delivery against the medication chart and any pharmacy errors recorded and fed back to the supplying pharmacy.  Staff responsible for the administering of medications have completed annual medication competencies and annual medication education. The standing orders have been approved by the GPs annually and meet the legislative requirements for standing orders. There was one self-medicating resident on the day of audit. A self-medicating competency, three monthly reviews and monitoring were in place. The medication fridge has temperatures recorded daily and these are within acceptable ranges.  Ten medication charts were reviewed. Photo identification and allergy status were on all ten charts. All medication charts had been reviewed by the GP at least three monthly. Ten resident medication administration-signing sheets corresponded with the medication chart. The service is in the process of initiating an electronic medication administration and management system. This was due to be implemented the week of the audit. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The cook oversees the food services. An external dietitian has approved the menu. All baking and meals are cooked on-site in the main kitchen. Meals are served directly to the residents in the adjacent dining room. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated.  End cooked food temperatures are recorded for each meal daily. Temperatures are recorded on all chilled and frozen food deliveries. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained.  Food services staff have complete on-site food safety education and chemical safety. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/EPOA. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry were declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | In the files reviewed, the InterRAI assessment tools had been used for the residents admitted under the ARRC agreement. A nursing assessment and care plan were completed on admission. As well as using InterRAI assessments, the resident files also included a full range of paper-based assessments to assist with resident care planning. Files reviewed identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional assessments for management of behaviour, wound care and restraint were completed according to need. However, two residents assessed as high falls risk did not have falls prevention strategies included in the care plan (link 1.3.61). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed demonstrated service integration and input from allied health. All resident care plans sampled were resident centred however not all support needs and interventions were documented (link 1.3.6.1). Residents and family members interviewed confirm they are involved in the development and review of care plans. Care plans were amended to reflect changes in health status and were reviewed on a regular basis. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Three of five care plans reviewed included interventions that reflected the resident’s current needs. However, there is a lack of interventions around falls prevention included in the long-term care plans. Staff reported that there were no working sensor mats available for the use of residents identified as a high falls risk.  When a resident’s condition changes the RN initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.  Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the clinical nurse manager interviewed. Care staff interviewed state there are adequate continence and wound care supplies.  The enrolled nurse and clinical nurse manager review all wounds. Wound assessment, wound management and evaluation forms and short-term care plans were in place for three minor wounds, with one wound included in the long-term care plan (one skin tear, one surgical wound and one infected in-growing toenail). There are currently no pressure injuries.  Monitoring charts were well utilised at Ocean View and examples sighted included (but not limited to), weight and vital signs, blood glucose, restraint, turning charts, bowels and continence. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs a recreation officer four days per week.  Each resident has an individual activities assessment on admission, which is incorporated into the InterRAI assessment process. The recreation officer, in consultation with the registered nurse and clinical nurse manager, develops an individual activities plan for each resident. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All long-term resident files sampled have a recent activities plan within the care plan and is appraised at least six monthly when the care plan is evaluated or a further InterRAI assessment occurs. Residents interviewed commented positively on the activity programme.  Residents/family have the opportunity to provide feedback on the activity programme through resident meetings and satisfaction surveys. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Four of five resident files reviewed had been evaluated six monthly by the clinical nurse manager, or with a change in health condition. One resident had not been at the service six months. Written evaluations describe the resident’s progress against the residents identified goals. InterRAI assessments have been utilised in conjunction with the six monthly reviews. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the clinical nurse manager, GP, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three monthly review by the general practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits. |
| 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. | FA | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident’s condition had changed and the resident was reassessed for a higher or different level of care. Discussion with the clinical nurse manager identified that the service has access to a wide range of support either through the GP, specialists and contracted allied services. |
| 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 substances, generated during service delivery. | FA | There is a chemical/substance safety policy and waste management policy. Management of waste and hazardous substances is covered during orientation of new staff. Chemicals are stored safely in a locked cupboard. Safety data sheets and product wall charts are available. All chemicals were labelled correctly. Gloves, aprons, and goggles are available for staff at the point of use. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. There is a chemical spills kit available. Staff have attended chemical safety training with the approved provider for chemicals. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building has a current building warrant of fitness that expires 2 June 2016. Reactive maintenance (maintenance requests logbooks) and a 52-week planned maintenance schedule are in place and maintained. The maintenance person is currently the owner. Medical equipment including hoists and weighing scales have been calibrated. Electrical testing and tagging has been completed annually. However, the chair lift had not been tested and tagged. The hot water temperatures are monitored weekly and are maintained between 43-45 degrees Celsius. The maintenance person/owner is on call and there are contractors for essential service available 24/7.  Environmental improvements completed include refurbishment, including some decorating.  The wide corridors and rails promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained, including the front garden and wooden elevated decking. There is outdoor furniture and seating. There is safe wheelchair access to all communal areas. There is an outdoor designated smoking area on the decking.  The caregivers and registered nurse interviewed stated that they do not have working sensor mats (link 1.3.6.1). |
| 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. | FA | Two bedrooms have access to hand basins. Two rooms have shared ensuites. All other rooms have communal bathrooms and toilets. There are adequate numbers of communal toilets and shower rooms for the number of residents. There are communal toilets located close to communal areas. Toilets have privacy locks. There is appropriate signage, easy clean flooring and fixtures, and handrails appropriately placed. Residents interviewed report their privacy is maintained. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All bedrooms are single. The rooms are spacious enough to manoeuvre transferring and mobility equipment, to deliver the assessed level of care. Residents are encouraged to personalise their bedrooms as desired. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a lounge and separate dining room and smaller seating areas for quiet activities such as reading or for visitors. The dining room is comfortable and spacious and adjacent to the kitchen.  Residents (as able) were observed to be moving freely with the use of mobility aids. Furniture was well arranged to facilitate this. The lounge accommodates specialised lounge chairs. Seating and space is arranged to allow both individual and group activities to occur. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry and personal clothing is laundered on-site. There are laundry/housekeeper persons on duty five days a week. There are defined clean/dirty areas. Cleaner’s trolleys are stored in locked areas when not in use. There were adequate linen supplies sighted in the facility linen-store cupboards. The chemical provider audits the effectiveness of chemicals for laundry and cleaning services.  The clinical nurse manager oversees the housekeeper/laundry services. Residents and relatives interviewed are happy with the laundry and cleaning services provided. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The facility has an approved fire evacuation plan and fire drills take place six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup. There are civil defence kits in the facility and stored water. Call bells are evident in residents’ rooms, lounge areas and toilets/bathrooms. The facility is secured at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility has heating throughout the personal and communal areas. All communal areas and bedrooms are well ventilated and light. Residents and family interviewed, stated the temperature of the facility is comfortable. |
| Standard 3.1: Infection control management  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. | PA Low | Ocean View 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 clinical nurse manager (registered nurse) is the designated infection control coordinator with support from all staff. Minutes of meetings held are available for staff. There was no signed job description for the infection control coordinator (link 1.2.7.4). Spot infection control audits have been conducted regarding infection control practices. Education is provided for all new staff on orientation. The infection control programme has not been reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) have good external support from the local 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. |
| Standard 3.3: Policies and procedures  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. | FA | There are infection control policies and procedures appropriate 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. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator attends the infection control forums at the DHB and is provided with education and updates through this forum. 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. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in Ocean View’s infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly. Outcomes and actions are discussed at quality/staff meetings (link 1.2 3.6). If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have been no outbreaks since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented, and implementation is reviewed through facility meetings. Interviews with the staff confirm their understanding of restraints and enablers.  Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had one resident using two restraints (bedrails and a wheelchair lap belt safety harness). No residents were using an enabler. |
| Standard 2.2.1: Restraint approval and processes  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 and others. | FA | The enrolled nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. The restraint coordinator did not have a signed job description on the day of audit (link 1.2.7.4). |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint assessments are based on information in the care plan, resident discussions and on observations by the staff. There was a restraint assessment tool completed for the one resident requiring bedrails and a wheelchair safety harness for safety. Ongoing consultation with the resident and EPOA is also identified. Falls risk assessments are completed six monthly and InterRAI assessment identifies risk and need for restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process, as part of the restraint minimisation policy that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used.  The care plan of the one resident with restraint, identified observations and monitoring. Restraint use is reviewed through the three monthly assessment evaluations, monthly restraint meetings and six monthly multidisciplinary meeting and includes family/EPOA input. A restraint register is in place, which has been completed for the one resident requiring restraint. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Evaluation has occurred three monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of their care plan review. The family is included as part of the MDR review. Evaluation timeframes are determined by policy and risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Individual approved restraint is reviewed at least monthly through the restraint meeting. The scheduled audit on restraint practices has not occurred in the 12 months (link1.2.3.5). |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.4.3  The organisation plans to ensure Māori receive services commensurate with their needs. | PA Low | There is a documented policy for cultural and spiritual awareness, however this policy does not include guidance on culturally safe care practices for Māori and the service does not have a Māori Health plan to meet contractual obligations. The service recently had a staff member leave who acted as a link with Iwi and no new link has been identified. Staff interviewed reported appropriate interventions to meet the needs of Māori residents. However, the cultural needs were not documented in the care plans. | (i) Ocean View does not have a documented Māori Health Care plan.  (ii) There is no documented policy, which outlines specific Māori values and beliefs, or culturally safe practices for Māori.  (iii) Ocean View staff interviewed could not describe links with the local Māori community.  (iv) Two residents who identified as Māori did not have their cultural values and beliefs documented in their care plan. | (i) Ensure that Ocean View has a documented Māori Health care plan that meets all legislative and contractual requirements.  (ii) Ensure that there is a documented policy on cultural safety care practices for Māori.  (iii) Ensure that appropriate links are established with local Iwi and the Māori community.  (iv) Ensure that all residents who identify as Māori have their cultural values and beliefs documented in their care plan.  90 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 requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | Ocean View has documented policies to guide safe practice. However, the documented policies do not all reflect current best practice, and some mandatory policies were not documented. | i) Ocean View does not have a documented policy for informed consent, death of a resident and safe food handling.  ii) The policy for challenging behaviour, does not comply with current best practice.  iii) InterRAI requirements have not been included in the care planning or organisational policy documents. | i-iii) Ensure that all mandatory polices are documented and all organisational polices meet current best practice, legislative and contractual requirements.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | The organisation has a quality management system in place that schedules the audits and monitoring required. Not all scheduled monitoring or audits had been completed. Data is not consistently analysed to identify areas for improvements. The care staff interviewed reported that quality data is occasionally posted on the staff notice boards. Internal audit results and adverse event results are not being consistently communicated to staff via staff notice boards or at quality/staff meetings. | i) Not all internal audits and monitoring identified on the organisation audit planner have been completed.  ii) Data collected for quality and risk management purposes is not always analysed with results communicated to staff. | i) Ensure that all scheduled audits and monitoring is completed.  Ii) Ensure that data collected is analysed and shared with staff.  60 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Where audit and monitoring results are less than the expected standard, corrective action plans (CAPs) are intended to be developed for areas requiring improvement. Not all areas requiring improvement had documented corrective action plans in place. The facility manager advised that once a corrective action plan has been implemented the corrective action plan is reviewed and then signed off as completed by the facility manager. Not all corrective action plans sighted had been reviewed or signed off by the facility manager. | i) Not all areas for improvement identified through the audit, monitoring process and staff and resident satisfaction surveys had corrective action plans documented.  ii) Not all corrective action plans had been reviewed or signed off as completed. | i) Ensure that corrective action plans are developed for all areas requiring improvements.  ii) Ensure that all corrective action plans are reviewed and signed off once completed.  60 days |
| Criterion 1.2.3.9  Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Moderate | There is a Health and Safety Manual in place, which provides guidance on the management of risks within the organisation. The health and safety register was last reviewed in March 2016. Not all hazards identified on the day of audit were included on the register and no risk management strategies had been implemented. | i) The care staff interviewed advised that two residents were currently using electric blankets and no risk management strategies had been documented or implemented.  ii) The current use of electric blankets by residents was not identified as a hazard on the hazard register. | i) Ensure that all identified hazards have risk management strategies documented and implemented.  ii) Ensure all hazards are identified and included on the hazard register.  30 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | All staff are required to have signed job descriptions, which outline the requirements of their role. Not all staff had signed job descriptions on file. | i) Two of six files reviewed did not have a signed job description on file.  ii) Job descriptions were not signed for the role of the infection control coordinator or restraint coordinator. | i) Ensure that all staff have a signed job description.  ii) Ensure that job descriptions are signed for all roles.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The service has an annual education planner that has scheduled education to cover the requirements of the Age Related Resident Contract. Not all topics outlined on the schedule have been delivered. Where training has occurred staff attendance has been low. | i) Education has not been provided in the past 2 years for advocacy and cultural awareness.  ii) Where staff attendance numbers have been low at mandatory education sessions provided, no follow-up education or training has been provided. | i) Ensure that the education schedule is fully implemented and education is provided to cover all contractual and legal requirements.  ii) Ensure that a process is put in place to ensure that all staff attend mandatory education and where attendance is low an education follow-up plan is implemented.  90 days |
| 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. | PA Low | Residents and family/whānau confirmed on interview they had received all relevant information on admission. The information pack contains information on the service, residents’ rights and advocacy brochure. Exclusions from the service are included in the admission agreement. The admission agreement in use does not comply with the requirements of the ARRC. | i) The amendments made in 2015 to clause D13.3 of the ARRC contract, regarding refund timeframes are not included in the admission agreement currently in use by the service.  ii) Schedule One of Ocean View’s admission agreement lists additional service charges to be paid by the resident (medication and transport costs), which are required to be provided by the service under the terms of the ARRC agreement.  iii) Schedule one state the room may be sublet if the resident is away from the facility. | i) Ensure that the current admission agreement aligns to the ARRC contract.  ii) Ensure that residents are not charged for services that are required to be provided by the service as outlined in the ARRC.  30 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Two residents identified as having a history of falls were witnessed mobilising independently. One resident was witnessed in their room with a call bell within easy reach. The long-term care plans include interventions such as, encourage resident to use the call bell, walk with mobility aid and wear correct footwear. Care staff interviewed were aware of residents who are high falls risk and stated that they monitor their mobility and answer call bells immediately. There are no working sensor mats available and staff stated that they have requested replacements be made available. | Two residents identified as having a history of a high number of falls had little falls prevention included in the long-term care plans. The staff report that there are no working sensor mats available. | Ensure that residents identified as a high falls risk have a full falls preventions included in their long-term care plan. Ensure that sensor mats are made available for residents identified as a high falls risk attempting to mobilise independently.  60 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Moderate | Medical equipment has been electronically tested and tagged, including the hoist and weighing scales. There is a chair lift on the stairs to the downstairs, which is used by one resident who lives in the lower ground floor room. This chair lift had not been electronically tested and tagged. There was evidence that all electrical equipment brought into the facility had been tested. | One chair lift connecting the lower ground floor room with the upper ground floor had not been tested and tagged. One of the supports holding up a deck on the north eastern side of the building was split on the day of audit. This support had two pieces of timber placed over the split that were being held in place by a G clamp. The facility manager advised that the owner had arranged for this support to be repaired the week after the audit | Ensure that the chairlift is tested and tagged annually.  ii)Ensure that all essential reactive maintenance is completed  30 days |
| Criterion 3.1.3  The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | The clinical nurse manager reports on the implementation of the infection control programmes to the quality/staff meeting. The infection control programme has not been reviewed in the past 12 months. | The infection control programme has not been reviewed in the past 12 months. | Ensure that the infection control programme is reviewed annually.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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End of the report.