# Wairarapa Village Limited - Wairarapa Village

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Wairarapa Village Limited

**Premises audited:** Wairarapa Village

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

**Dates of audit:** Start date: 30 May 2016 End date: 31 May 2016

**Proposed changes to current services (if any):** The facility is being sold and is having a provisional audit undertaken to establish the prospective owner’s preparedness to provide a health and disability service and the level of conformity with the required standards.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 34

# 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.

## General overview of the audit

Metlifecare Wairarapa Village facility which is a 44 bed facility for residents requiring rest home and hospital level care. There is also a village on the site which is not subject to this audit. Three service streams were reviewed being rest home, hospital and residential non-aged care. This provisional audit was undertaken to establish the prospective owner’s preparedness to provide a health and disability service and the level of conformity with the required standards.

The audit was conducted against the Health and Disability Services Standards and the provider’s contracts with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, family/whānau, management, staff, the general practitioner, the current provider and the prospective owner.

The existing services have four areas identified for improvement in relation to timeliness of assessments by the general practitioner or nurse practitioner following a resident’s admission, non-medical assessments of residents, electrical checks of equipment and emergency water storage. The ten areas identified for improvement from the previous audit have all been addressed.

The prospective provider has aged care management experience and has no immediate plans to change any systems or services. Staff, residents and family/whānau are aware of the upcoming change of ownership as confirmed during interviews. This has been an open and transparent process with meetings being held to allow any queries to be answered.

## Consumer rights

Care provided to residents is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected.

There is one resident who identifies as Maori at the time of audit and appropriate policies, procedures and community connections ensure culturally appropriate support is provided.

Residents interviewed feel safe, there is no sign of harassment or discrimination, staff communicated effectively and residents are kept up to date with information. Residents, or their enduring power of attorney, sign a consent form on entry to the service with separate consents obtained for specific events.

The service informs residents and their families of how to access the Nationwide Health and Disability Advocacy Service and encourages residents to maintain connections with family, friends and their community and to access as many community opportunities as possible.

The service has a documented complaints management system which is implemented. All complaints sighted have been addressed within required timeframes. The facility confirms there are no outstanding complaints at the time of audit and that all complaints have been fully resolved in house. The perspective owner understands the complaints process.

## Organisational management

The service has a business and quality plan in place. The organisation’s mission statement, goals and philosophy as currently documented will be continued by the prospective owner to ensure residents’ needs continue to be met. The prospective owner stated that a new business plan is under draft to show the new organisational structure. The plan will identify the new governance and management structure. There is no documented transition plan as the prospective owing stated that nothing will change under the new ownership. The existing policies and procedures will be maintained along with the quality and risk management systems and staffing levels.

The current documented quality and risk systems and processes support safe service delivery. The quality management systems include identification of hazards, staff education and training, an internal audit process, complaints management, and data gathering and reporting of incidents/accidents, restraint and infections.

Human resources management processes and the current documented staff education will continue to be offered. The prospective owner is experienced in aged care management and verbalised a clear understanding of human resources requirements. Existing staff will be given the opportunity for continued employment. The current nurse manager intends to remain in the role and will oversee all clinical services.

Residents’ information is accurately recorded, and all information was securely stored and not accessible to the public. Service providers used up to date and relevant residents’ records.

## Continuum of service delivery

The organisation works closely with the Needs Assessment Service Co-ordination Service to ensure access to the service is efficient and relevant information is provided, whenever there is a vacancy.

Residents’ needs are assessed on admission by the multidisciplinary team. All residents’ files sighted provided evidence that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

## Safe and appropriate environment

Services are provided in a clean, secure environment that is appropriate to the level of care provided. There are appropriate amenities to meet residents’ needs and to facilitate independence. Residents, visitors and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery. There are adequate toilets, showers and bathing facilities.

Documentation identifies that all processes are maintained to meet the requirements of the building warrant of fitness. Planned and reactive maintenance is documented. The prospective owner is aware that not all electrical safety checking has been undertaken.

Systems are in place for essential, emergency and security services. Six monthly emergency evacuation drills have occurred. The service does not hold enough emergency water and the prospective owner is also aware of this.

All residents have access to outdoor areas.

The prospective provider has no plans to make environmental changes to the facility footprint.

## Restraint minimisation and safe practice

Policies and procedures in place reflect current good practice and meet legislative and Health and Disability Services Standard requirements. Staff education related to restraint management has occurred in March 2015.

At the time of audit there is one chair lap belt restraint and seven enablers (three chair lap belts and four bedside rails) in use.

The service ensures all assessment, review and monitoring processes are maintained related to restraint minimisation and safe practice.

Audit and restraint quality review results identify compliance with policy.

## Infection prevention and control

The service provides an environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control coordinator reporting directly to the nurse manager who report to the owner.

There is an infection prevention and control programme for which external advice and support was sought; this is reviewed annually. An infection control co-ordinator is responsible for this programme, including education and surveillance.

Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. Surveillance results are benchmarked with an external provider. The results of surveillance are reported through all levels of the organisation, including governance.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 46 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 3 | 1 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **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 | Interviews with residents and family members of residents verified services provided complied with consumer rights legislation.  Policy documents, the staff orientation programme, in-service training records, education programmes, interviews with staff, and satisfaction surveys verified staff knowledge of the Code of Health and Disability Services Consumers’ Rights (the Code).  Clinical staff were observed to explain procedures, seek verbal acknowledgement for a procedure to proceed, protect residents' privacy, and address residents by their preferred name. |
| 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 | The informed consent policy describes all procedures to ensure the resident’s rights to be informed of all procedures undertaken.  Documentation, observation and interviews provided evidence that information is provided to make informed choices. Informed consent is understood and is included in the admission process. The resident, and where desired family/whanau, are informed of changes in the resident’s condition and care needs, including medication changes. Residents’ choices and decisions, including advance directives, are recorded and acted on where valid. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The service recognises and facilitates the rights of residents and their family/whanau to advocacy/support by persons of their choice. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally. Residents and their families are aware of their right to have support persons.  At the time of admission to the service residents are given information on the Nationwide Health and Disability Advocacy Service (Advocacy Service) including contact details. Residents and family members confirmed on interview their awareness of the advocacy service and how to access this. |
| 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 assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations, with the support of the service. The service acknowledges values and encourages the involvement of families/whanau in the provision of care. The activities programme actively supports community involvement. |
| 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 register which shows that processes are managed according to policy timeframes. The nurse manager confirms that complaints are registered electronically and in hard copy. Staff, residents and family/whānau understand the complaints procedure and have access to complaints forms at all times. All complaints have been resolved in-house since the previous audit. This is confirmed in the complaints register sighted which shows the complaint made, the date it was lodged and the completed follow up. At the time of audit there are no outstanding complaints. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Interviews, observations and documentation verified residents are informed of their rights. Information on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service is displayed and accessible to residents.  Discussion, clarification and explanation on the Code and the Advocacy Service occurs at admission. This is discussed with new residents and their family by a registered nurse at that time, and followed by discussions/clarifications on an as-required basis.  Legal advice is able to be sought on the admission agreement or any aspect of the service. Information is provided on the facility’s range of costs and services.  The prospective provider has had previous experience working in the sector. Interview verifies knowledge and understanding of consumer rights legislation and the obligations of the service to adhere to the Code. Residents and families interviewed verified being informed of a prospective change in ownership through on site meetings and letters. All expressed satisfaction with the process. |
| 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 | Policy identifies that procedures are in place to ensure residents are kept free from discrimination, harassment, abuse and neglect, including the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. Residents receive services which treat them with respect and has regard for their dignity, privacy, sexuality, spirituality and independence. The privacy of resident information is maintained. All residents’ clinical files are held in the nurses’ station, personal information in administration files is password protected and archived records are stored securely. The privacy of resident information is maintained during the verbal handover from one shift to the next.  Staff demonstrated policy awareness and responsiveness to residents’ needs. Staff were noted to knock on residents’ doors before entering, addressing residents by their preferred name and ensuring that residents’ privacy was maintained during personal cares. The service’s policy related to abuse and neglect was well understood by those staff interviewed. They were able to provide examples of what would constitute abuse and neglect and the actions they would take if they suspected this.  Residents and families interviewed confirmed that residents were treated respectfully at all times. |
| 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. | FA | The service has a detailed Maori Health Plan. This plan includes an action plan which includes a range of activities to be completed to ensure the needs of residents who identify as Maori are met. The plan also includes a range of information to help guide staff, including the contact details of a number of individuals and organisation who could provide any required cultural support and/or guidance.  The service currently has two staff that identify as Maori, including a kaumatua who is available for room blessings and other cultural support as required. A whanau room is available if required. A Maori resident interviewed confirmed their needs were being met in an appropriate and culturally safe manner. |
| 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 | Policy and evidence verified residents’ received and are consulted on culturally safe services which recognised and respected their ethnic, cultural and spiritual values and beliefs. Residents’ personal preferences and special requirements were included in all care plans reviewed, with appropriate interventions included to ensure these were met. There was also evidence in those care plans of the resident and/or their family being involved in their development and ongoing evaluation. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policy indicates that residents are to be free from all forms of discrimination, coercion, harassment and exploitations. Orientation/induction processes inform staff on the Code. The company’s house rules, policies and procedures provide clear guidelines on professional boundaries and conduct and inform staff about working within their professional boundaries.  Interviews verified staffs understanding. Residents felt safe and received a high standard of support and assistance and reported there was no sign of harassment or discrimination. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages good practice. Policies sighted are current, relevant, reflected current best practice and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies are monitored and evaluated at organisational and facility level. Evidence verified a range of opportunities is provided to enable staff to provide services of a high standard.  Registered nurses are available 24 hours a day to provide guidance for care delivery staff.  The senior registered nurse advised the service has well established clinical networks and is able to draw on a range of clinical specialist resources to provide advice and direction with clinical care. These include speech language therapists, occupational therapists, the hospice service, diabetes nurse specialist, district nurses and wound nurse specialists. Evidence was sighted in a number of residents’ files of clinical speciality input/guidance into service provision.  The nurse practitioner (NP) confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policy identified that interpreter services are available and offered to residents with English as a second language. The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided. Communication with relatives is documented in the residents’ communication records and incident forms. Evidence was sighted of resident/family input into the care planning process. Residents advised on interview that staff kept them well informed and that the senior nurses had an open door policy if they wanted to discuss anything. All family members interviewed stated they were informed in a timely manner about any changes to the resident’s status and verified an environment conducive to effective communication.  Resident meetings are held monthly. The minutes of these meetings confirmed active resident participation in this communication forum, with residents having the opportunity to raise issues with staff, such as the cook and the nurse manager.  Residents and families interviewed verified being informed of a prospective change in ownership through on site meetings and letters. All expressed satisfaction with the process and are comfortable addressing any concerns they have now or in the future with the nurse manager/prospective owner. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | On the day of audit 34 beds are occupied; 18 rest home level care, one being a person on a non-aged care contract; and 16 hospital level care, five of which are non-aged care. This resulted in review of three residents in detail using tracer methodology.  The current service has a business plan which identifies the organisation’s mission statement, vision and philosophy and shows the organisation’s planning process to meet residents’ needs. The prospective owner will use the current business planning processes until he is well established. He is aware that the direction and goals of the organisation need to be reviewed regularly. He is in the process of developing a business plan to show the new governance structure. The new owners (two family groups) will operate as a board of trustees, with all services being overseen by the general manager who represented the group during audit. The general manager is experienced in this role and has worked in the New Zealand Aged care industry at governance level for over 16 years.  The planned takeover date is the 30th June 2016.  The quality programmes and procedures described in policy include, hazard management, staff training and education, data reporting of incidents/accidents, infections, restraint and internal audit. The proposed owner will use the existing quality programme data to identify trends and improve services.  Interviews with residents and family/whānau confirmed that their needs were met by the service. They have been kept informed of the pending change of ownership and this is confirmed in meeting minutes sighted. |
| 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 | Currently during a temporary absence of the village manager or the nurse manager they cover each other’s roles with input from the senior registered nurse for clinical input. Assistance is also given by Metlifecare head office as required.  The prospective owner stated he has set up a support system with a nearby facility whose senior management staff can be called on for assistance or advice as required. He is aware of the need to ensure suitably qualified and experienced management persons need to be available at all times.  All staff have been offered contracts with the current terms and conditions to remain. |
| 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. | FA | The service has a business plan and quality and risk processes in place which cover all aspects of service delivery. The quality planning policy identifies generalised goals and objectives and the measure used to identify how the controls are effective or responsive to residents’ needs. This includes key components of service such as complaints management, infection control, health and safety and human resources management. Quality data collection and analysis occurs to identify areas of deficit. Senior staff confirm they understand the processes in place. Corrective actions are taken to improve services, such as those documented to reduce residents’ falls and address medication errors. The prospective owner expects to receive regular reports against set goals to be documented by the nurse manager and the village manager. He will be on-site daily for the first month and then at least one week a month or more if required.  The internal audit system is one process used to measure achievement against the quality and risk management plan. Results will be used by the prospective owner to measure progress of the service delivery. He will trend against previously collected data. The service is in the process of establishing a quality group which is due to meet in June 2016. (Documentation sighted).  Current policies and procedures will remain in place and will be updated when the new owner is fully established in the business as each one becomes due. The use of the Metlifecare policies and procedures has been agreed as part of the purchase of the business. A rebranding exercise will occur with the name change going from Metlifecare Wairarapa Village to Wairarapa Village Limited.  Actual and potential risks are identified and documented in the hazard register. The village manager oversees all health and safety issues. He has undertaken education to ensure he is aware of all current legislative requirements, such as ladder safety, and the service has all new ladders in place. The health and safety committee who meet monthly have a representative from all areas of service. Staff confirmed their awareness of known hazards and that they understood and implemented documented hazard identification processes. The village manager’s role will remain the same following takeover.  There were no negative comments from resident and family/whānau interviews. |
| 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 | Policy is implemented related to adverse events. The nurse manager fully understood the obligations in relation to essential notification reporting and knows which regulatory bodies must be notified as identified in policy including pressure injuries. A section 31 report for a resident suffering a fall resulting in a fracture was sighted.  Staff interviewed stated they report and record all incidents and accidents on a specific form. Adverse event information is used to improve services. All incidents and accidents are reviewed at the senior management clinical meetings held quarterly and follow-up actions are monitored.  Family/whānau are notified of any adverse, unplanned or untoward events at all times. This was identified on incident and accident forms sighted and in residents’ files reviewed. Family/whānau interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives.  The prospective owner is conversant with legislative and compliance issues which may impact on the service. At the time of audit there are no legislative known compliance issues concerning health and safety, employment or local body that could affect the service. |
| 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. | FA | Human resources policies describe good employment practices that meet the requirements of legislation. Newly appointed staff are police vetted upon employment, referees are checked and job descriptions clearly described staff responsibilities. Staff complete an orientation/induction programme with specific competencies for their roles, such as medication management, as confirmed during staff file reviews. Staff that require professional qualifications have them validated as part of the employment process and annually. The prospective owner does not intend to change employment processes.  There is an education plan in place for 2016 staff education. Education and training undertaken by staff to the time of audit is recorded for each individual staff member and the content of education offered is appropriate to the services delivered. Staff confirmed during interview that they are offered in-service and off-site education related to their roles.  Resident and family/whānau members interviewed identified that services are delivered in a professional manner. No negative comments were voiced during interviews on the day of audit. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service implements a documented process for ensuring staffing levels allow safe and efficient services to be delivered to residents to meet all their identified needs. Rosters sighted identify that staff are replaced for annual leave or sick leave. All shifts are covered by a registered nurse and a staff member who holds a current first aid certificate.  Five rest home rooms are located in the service apartments. At the time of audit only four rooms were being used for rest home level care, they are spread throughout the serviced apartment area. The nurse manager stated that an additional staff member is rostered on all shifts to cover these residents. For example, there are three staff on night duty with one staff being allocated to respond to service apartment residents’ call bells.  During interview staff reported that they have sufficient time and staff to complete their required duties.  The prospective owner intends to maintain the current staffing levels. He stated the nurse manager will be responsible for ensuring the service continues to roster the correct skill mix of staff required for a hospital and rest home complex.  Residents interviewed stated all their needs have been met in a timely manner. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There was no personal or private resident information on public display during the audit. The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all resident's information sighted. Staff update residents progress notes every shift and a consistent record of the name and designation of the staff member making the entry is sighted. Clinical notes are current and integrated with GP, nurse practitioner (NP) and auxiliary staff notes.  The files are kept secure and are only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP or NP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI number, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers are all recorded in each resident’s record.  Archived records were being held on site in a secure room. These are catalogued for easy retrieval. |
| 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. | FA | The senior registered nurse outlined the processes associated with service entry. Prospective residents are provided with detailed information about the service. They are also advised they can only be admitted when their level of required care has been assessed and confirmed by the Needs Assessment Service Co-ordination Service.  Information about the service, includes full details of the services provided, its location and hours, how the service is accessed and identifies the process if a resident requires a change in the care provided.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them as part of that process. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the 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 | All aspects of medication management are consistent with legislative requirements and safe practice guidelines, as evidenced by documentation, observation and interview. All previous identified corrective actions concerning expired medications, medicine reconciliation by the RN, management of residents self-administering medication and accuracy of administration records, have been addressed.  A safe system for medicine management is observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Staff who administer medicines are competent to perform the function they manage.  Controlled drugs are stored in a separate locked cupboard. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.  The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.  The GP’s signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart. Residents’ allergy status was documented, and medication administration records were complete.  The RN advised that medications are checked against the medication chart by a RN on arrival to the service. All medications in the medication trolleys and stock cupboards were within current use date. The date of first use of eye drops was recorded on those products currently in use. Surplus and expired medication is returned to the pharmacy.  Residents who self-administer their medicines have appropriate processes in place to ensure this is managed in a safe manner.  Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis and management of any medication errors and compliance with this process is verified.  Standing orders are not used. |
| 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 food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian’s February 2016 documented assessment of the planned menu.  A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is sighted.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The local council’s certificate of registration expires 31 March 2017. Evidence was sighted of a 13 May 2016 audit by the council to assist in implementing the service’s food control plan.  The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification of compliance.  Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews and resident meeting minutes.  There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.  There is an effective and systematic approach to ensuring that residents’ nutrition and fluid intake is carefully monitored, while clinical staff ensure residents are weighed monthly. |
| 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 | An interview with the senior registered nurse verified a process existed for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry is communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | As verified by observation, interviews and documentation, on admission, residents have their needs identified through a variety of information sources that includes the Needs Assessment Co-ordination Service agency, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools.  The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident’s bedroom with the resident and/or family/whanau present if requested.  Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated. Assessments are reviewed six monthly or as needs, outcomes and goals of the resident change, however not all of the residents’ records reviewed contained a current interRAI assessment or current clinical assessments.  A medical review is undertaken monthly or three monthly if the GP documents the resident is stable. A multidisciplinary assessment is undertaken yearly. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | A comprehensive electronic lifestyle care plan has been implemented by the service and details the required interventions to achieve the residents’ desired outcomes. A previous corrective action identifying not all care plans included adequate information to reflect current needs, has been addressed.  Files reviewed evidence all residents have an individualised care plan. The assessment findings (refer 1.3.4.2) in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support the resident requires from care staff, to meet their goals and desired outcomes.  Care plans evidence service integration with progress notes, activities notes, and medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned. Short term care plans are used for managing residents’ short term problems (eg, infections).  Care plans are evaluated six monthly or more frequently as the resident's condition dictated. Residents and families interviewed confirmed their participation in the development of care plans and their ongoing evaluation and review. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents’ needs and desired outcomes. The nurse manager and the senior RN are on call 24 hours a day to provide support and guidance for care delivery staff and well-established processes are in place to ensure continuity of care. An interview with the NP confirmed satisfaction with the standard of care provided to residents.  Residents and family/whanau members expressed satisfaction with the care provided. |
| 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 recreation officer advised that residents are assessed on admission to ascertain their previous and current interests, needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Interviews with the younger residents verified consideration is given to providing activities and outings specific to their interests. The service has internet access for residents, with Wi-Fi available to those with their own devices. A communal computer is accessible to all residents.  The residents’ individualised activity plan is reviewed as part of the care plan.  Documentation, observation and interviews verify activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.  A residents’ meeting is held monthly, with the cook and nurse manager invited to attend, at the residents’ request. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | As verified by documentation, observation and interview the RN is responsible for the evaluation of resident progress towards previously identified goals. Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN.  Formal care plan evaluations, that details the resident’s response to the support and interventions in relation to desired outcomes and goals, occur every six months or as a resident’s needs change. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.  A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. A previous corrective action identifying evaluations not occurring within the required timeframes has been addressed.  Interviews, verified residents and family/whanau are included and informed of all changes |
| 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 | Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP, NP or RN sends a referral to seek specialist service provider assistance from the District Health Board (DHB). Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Support is available to transport and accompany residents to health-related visits outside of the facility, such as hospital appointments or visits to the dentist, if there is no family member available to accompany them. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| 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 | All chemicals are securely stored. Chemicals are clearly labelled and safety data sheets are available. There are yellow bins for safe disposal of sharps and regular waste bin pick-ups for all other waste. Staff confirmed that they can access personal protective clothing and equipment at any time. As observed, disposable gloves and gowns are worn when required. Waste management meets legislative requirements. |
| 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 | Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current warrant of fitness which was issued on 24 June 2015.  Maintenance is undertaken by both internal maintenance and external contractors. Electrical safety test tags show this occurred in April 2016, however not all electrical items have been checked. Clinical equipment is tested and calibrated by an approved provider at least annually or when required.  The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is secure, bathroom floors are non-slip, and walking areas are not cluttered.  The service documents regular maintenance which identifies day to day maintenance occurs upon request in a timely manner. There are easily accessed shaded outdoor areas with suitable furnishings for resident use.  Interviews with residents and family/whānau members confirmed the environment was suitable to meet their needs.  The new owner does not have plans to change the current building footprint. |
| 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 of the residents’ bedrooms in the care facility have full ensuite facilities and all other bedrooms have toilet and hand washing facilities only. There are centrally located shower and bathroom areas. The rest home level care residents who are managed in the serviced apartments all have full ensuites. There is a designated staff/visitor toilet.  One bathroom has some chipping at the base of the Formica walling. This is on the maintenance schedule sighted for repair. The maintenance person stated the work would be completed within the week to ensure it remains compliant with infection control standards. The prospective owner is aware of the repairs to be undertaken.  The village manager and the maintenance person confirmed hot water temperatures are checked monthly and kept within a safe range for an aged care facility. This is undertaken as part of the monthly monitoring requirements for the environmental checks. |
| 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 of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Bedrooms are personalised to meet resident’s wants and needs and have appropriate areas for residents to place personal belongings. All bedrooms are single occupancy. Younger residents have larger bedrooms for better storage of their mobility equipment.  Resident and family/whānau members interviewed did not identify any concerns related to personal bed space. |
| 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 | Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. The dining and lounge areas are separated. The areas are appropriately furnished to meet residents’ needs. One lounge is generally used for activities and a second lounge (Willow lounge) is used as a quiet lounge and is used to for residents to entertain visitors if they wish.  Residents and family/whānau voiced their satisfaction with the environment and confirmed they are able to choose which lounge they use throughout the day. |
| 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 | There are secure storage areas for cleaning chemicals. Cleaning is undertaken seven days a week by dedicated cleaning staff. Tasks are clearly documented. The facility looked and smelled clean.  The laundry has a designated clean and dirty area. Newly purchased washing machines are regularly checked for appropriate use by the company which supplies the chemicals. The laundry operates seven days a week and is managed by dedicated staff. The laundry door is locked when a staff member is not in attendance.  Residents and family/whānau members interviewed had no negative comments related to cleaning or laundry. This is supported by the 2015 resident satisfaction survey results sighted which gained a 95% overall satisfaction rating. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | Policies and procedures guide staff actions in the event of an emergency. There is an emergency plan which includes the approved fire evacuation scheme. Policy identifies that six monthly emergency education, training and fire drills have been maintained. This last occurred in February 2016 with no follow up actions required. Safe use of fire extinguisher training occurred in May 2016.  All resident areas have smoke alarms and a sprinkler system to meet building code requirements.  Emergency supplies and equipment include food and water. The amount of stored water does not met the requirement of three litres per person per day for three days. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ.  Staff are required to ensure all doors and windows are secured after hours. There are security checks undertaken three times per night by an off-site security company. The grounds are monitored by cameras which can be viewed at the nurses’ station. There are outdoor security lights. Staff and residents interviewed confirmed they feel safe at all times.  There is a call bell system available for residents and staff to call for assistance if required. Weekly call bell response times are monitored by the nurse manager as confirmed in documentation sighted. |
| 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 is kept at a suitable temperature throughout the year via electric heating and the opening of doors of windows for ventilation. This was confirmed during resident and family/whānau interviews. The facility was very warm on the days of audit.  All resident areas have at least one opening window to provide adequate natural light. |
| 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. | FA | There are well developed processes and systems related to infection control (IC) management. The IC programme, reviewed annually (last in March 2016), establishes, maintains and monitors procedures covering IC practices. The senior registered nurse is the designated infection control coordinator (ICC) for the service, supported by the IC committee. This IC team is guided by two comprehensive and current resource manuals and is also able to utilise additional advice from specialists, such as the IC team at the District Health Board. It is the responsibility of all staff to adhere to the procedures and guidelines in the IC manual when carrying out all work practices.  All IC data is reported monthly to the nurse manager and meeting minutes recorded that IC is a standing agenda item at all facility meetings.  Staff demonstrated awareness of the circumstances that would require them to stay away from work if they were unwell. A sign at the main entrance to the facility asks visitors not to enter the facility if they are unwell. |
| 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 | The ICC is responsible for implementing the infection control programme and reports directly to the nurse manager. A position description is included in the IC programme. The training records for the ICC confirmed they have completed appropriate education for that role. The ICC is able to utilise a range of external resource information and has access to resident records and the results of diagnostic tests to ensure timely treatment and resolution of infections.  The infection control committee includes the nurse manager, the kitchen manager, the village manager, laundry manager and caregiver and registered nurse representatives. This committee has an appropriate range of skills and expertise for their role. The committee meeting minutes provide a detailed account of the quarterly meetings. The ICC advised that extra committee meetings can be called if necessary.  Every resident’s room is equipped with containers of disposable gloves and soap dispensers. Numerous hand sanitizer dispensers were sighted around the facility, including pumps on the medication and dressing trolleys. Personal protective equipment is freely available to staff, who confirmed the availability of this equipment. The service also maintains an appropriate supply of additional equipment in case of an infection outbreak (supplies were sighted). |
| 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 | An infection control policy/procedure manual guides infection prevention and control practices. These comply with relevant legislation and current accepted good practices. The manual is reviewed annually, with the last review being undertaken in March 2016. Housekeeping and kitchen staff were observed to be compliant with infection control practices. Care delivery staff were observed using hand-sanitizers on a regular basis and wearing disposable aprons and gloves as appropriate |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verify staff are required to attend annual infection prevention and control education. Education sessions are provided by suitably qualified educators including the ICC. Infection control is a component of the staff orientation programme. Additional staff training is also implemented in response to any acute infection control issues, such as an infection outbreak. Audits are undertaken to assess compliance with expectation.  The ICC advised that resident education occurs in a manner that recognises and meets the residents’ and the families’ communication style. Education with residents is generally on a one-to-one basis. This may include reminders about hand washing, the use of tissues, or the need for an increased fluid intake in warmer weather. |
| 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 | A surveillance programme is in place. Surveillance of infections (respiratory, skin, soft tissues, urinary tract, gastrointestinal and multidrug resistant infections) is the responsibility of the ICC.  Daily incidents of infections and the required management plan are presented daily at handover, to ensure early interventions. Monthly surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions.  Meeting minutes and interviews verify data is presented to the nurse manager and quality/staff meetings and any ongoing corrective actions discussed and implemented. Incidents of infections are benchmarked both internally and externally. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies and procedures in place to guide staff in the safe use of restraint. Policy identifies that the use of enablers is voluntary and should be the least restrictive option to meet the needs of the resident to promote independence and safety. At the time of audit there is one restraint and seven enablers. |
| 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 service implements policy and procedures related to restraint approval. The only restraints used are chair lap belts and bedside rails. The restraint coordinator has a process in place to ensure timeframes are met for ongoing approval and monitoring is maintained as per her role description requirements.  Policy states staff undertake bi-annual education related to restraint minimisation. This last occurred in March 2015. Challenging behaviour education occurred in October 2015. The content sighted is appropriate for the type of restraints used. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint is used for safety reasons only. The assessment tool used covers all of the requirements of this criterion. No new restraints have been put in place since the previous audit and the facility is working to reduce restraint use as much as possible. (One resident’s file was reviewed for restraint only and one for enabler use). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The only restraints used at the time of audit are bedside rails and chair lap belts. These are for safety only and approved by the organisation.  Prior to restraint use an assessment is undertaken, the resident and family/whānau are involved in the decision to use restraint or enablers and this is clearly documented in the resident’s file.  Staff verbalised their knowledge related to safe use of restraint during interviews. One resident with a chair lap belt confirmed it is only used when they leave the premises to allow them to feel safe in their chair when off site. This is identified in the care plan sighted and in the restraint register. All restraint is overseen by the restraint coordinator (RN) and discussed at staff and management meetings as confirmed in minutes sighted.  The restraint register has documented evidence to show the type of restraint or enabler used, the frequency of use and the monitoring to occur. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | When restraint is in use each episode is evaluated via use of monitoring forms. The timeframes for checking the resident is safe is shown on the restraint monitoring form and identified on the care plan.  Any resident who is using restraint or an enabler has a three monthly review undertaken by the restraint coordinator. This is documented in the restraint register. No changes to the current restraints in use were sighted. There have been no reported incidents related to restraint use since the previous audit. The resident and family/whānau are involved in any updates required as identified in the files reviewed. The resident and family/whānau are asked to give consent at least annually for any restraint or enabler which is ongoing. This process is well documented. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service can demonstrate that monitoring and quality review are undertaken. Audits were undertaken in April and May related to safe use of restraint and overall compliance with policy. Follow up required staff reminders to complete restraint monitoring forms correctly.  Meeting minutes sighted show that each restraint is reviewed quarterly by the restraint committee. Review for compliance and evaluation of use of restraint is completed for each resident with restraint or an enabler six monthly to ascertain the need to either continue or cease restraint use. The restraint register identifies that restraint is stopped if it is deemed safe to do so. This process is clearly documented. |

# 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 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Five of seven residents’ files evidence residents being reviewed by a GP or NP within 48 hours of admission. However, two residents recently admitted have not been seen within the 48 hour period as per the contractual requirement (D16.5 e i 1). Documentation from the GP is sighted documenting the inability to meet the 48 hour requirement due to a recent shortage of doctors. Acute visits are attended to, and the NP visits weekly. | One resident admitted to the facility in May 2016 and one in December 2015 was not seen by the GP or NP within 48 hours of admission. | Residents are seen within 48 hours of admission or within 48 hours prior to admission by a GP or NP.  180 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | Residents have their needs identified through a variety of information sources, including assessments as clinically indicated. Information gathered informs the care planning process. A documented process is in place to ensure all initial and ongoing assessments are performed, however the requirement for the interRai assessment tool to be used, has not yet been fully integrated into practice. Three of the seven files reviewed had either no interRAI assessment or an interRAI assessment that was not updated within the previous six months. The nurse manager verified not all residents had interRai assessments, though these would be completed within the next two months.  An additional two of the seven files reviewed, were for residents not required to be assessed using the interRAI assessment tool as they were admitted under the ‘younger person with a disability’ contract. Clinical assessment tools for these residents had not been updated within the last six months, as the RN thought an interRai assessment was required. | The needs, outcomes and goals of the resident are identified via the assessment process; however, not all residents have an initial interRAI assessment or evidence of ongoing assessments to serve as the basis for care planning. | Ensure all assessments are undertaken within required timeframes.  90 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | With the exception of electrical equipment all other buildings, plant and equipment sighted complies with legislation. All medical equipment sighted has been checked by an approved provider. | Not all electrical items sighted have been electrically tested. For example plugs and cords in the treatment room and items in residents’ bedrooms. | Provide evidence that all electrical equipment is checked according to legislative requirements.  180 days |
| Criterion 1.4.7.4  Alternative energy and utility sources are available in the event of the main supplies failing. | PA Low | There are gas BBQs, emergency lighting and food available should an emergency occurs. The service also has emergency water but not the required amount to meet best practice standards. | The water stored is only 60 litres and the minimum requirement is 396 litres for 44 residents. | Ensure there is enough stored water to meet emergency management requirements.  180 days |

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

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

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

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

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End of the report.