

M V and C D Hodson - Westella Homestead

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 Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: M V and C D Hodson

Premises audited: Westella Homestead

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 12 May 2016 End date: 12 May 2016

Proposed changes to current services (if any): The service provider is transitioning from rest home and dementia level care to dementia level care only.

Total beds occupied across all premises included in the audit on the first day of the audit: 25

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

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

General overview of the audit

Westella Homestead provides residential care for up to 26 residents who require rest home and rest home dementia care. The service provider is transitioning from rest home and dementia level care to dementia level care only. Occupancy was 25 during this audit. The facility is owned by M V and C D Hodson Partnership.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the District Health Board (DHB). The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

Four areas were identified as requiring improvement. The improvements relate to staff education, general practitioner reviews within the required timeframes, care planning documentation and aspects of food service.

Consumer rights

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| 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. | Green | Standards applicable to this service fully attained. |
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are all accessible. This information is brought to the attention of residents (where able), and their families on admission to the facility. Residents and family members confirmed their rights were being met, staff are respectful of their needs and communication was appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Written consent is gained as required. Residents and family members are provided with information prior to giving informed consent and time is provided if any discussions or explanations are required.

Staff receive regular and ongoing training on resident rights and how these should be implemented on a daily basis. Services are provided that respect the independence, personal privacy, individual needs and dignity of residents.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination or abuse and neglect, and these policies are understood by staff.

The facility manager is responsible for the management of complaints and a complaints register is maintained.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of low risk. |
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MV and CD Hodson Partnership is the governing body and are responsible for the service provided at Westella Homestead. Dalcam Healthcare Limited is contracted to provide management services at Westella Homestead. The strategic plan, business plan, mission statement, vision and values statements, and philosophy are documented. An organisational chart was also sighted.

An experienced facility manager, who is a registered nurse, is responsible for management of the facility and for oversight of clinical care. The facility manager is supported by the general manager from Dalcam Healthcare Ltd.

Quality indicators are reported. There is an internal audit programme and audits are completed. Risks are identified and there is a hazard register. Adverse events are documented. Internal audits, infection control surveillance, electronic accident/incident reports, meeting minutes and surveys evidenced analysis of data and the development of corrective action plans to address any issue/s that require improvement.

There are policies and procedures on human resource management. Job descriptions, orientation programme, performance appraisals, and evidence of police vetting are retained on staff files. Practising certificates are held on file for all health professionals who require them to practice.

In-service education is provided for staff. Caregivers are also supported to complete the New Zealand Qualifications Authority Unit Standards relating to aged care and dementia; staff have either completed the dementia specific education modules or are working towards completing them.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The facility manager and the registered nurse are available on call after hours. Care staff interviewed reported there is adequate staff available.

Continuum of service delivery

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| <p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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The organisation works closely with the Needs Assessment 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. There is evidence that needs, goals and outcomes are identified and reviewed on a regular basis, however at times this is not within the required timeframes and some interventions are not consistent with assessment findings. Residents and families interviewed reported being well informed and involved, and that the care provided meets residents' current needs

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 dietician as meeting nutritional guidelines, with any special dietary requirements and need for modified equipment met. Some aspects of food preparation and storage are not consistent with current legislation and guidelines and an improvement is required. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

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. | | Standards applicable to this service fully attained. |
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Westella Homestead is located on a three hectare site that is secured by electronic gates with security cameras and high fences. Residents are able to wander freely throughout the facility and grounds.

Building and plant comply with legislation and a current building warrant of fitness displayed. The preventative and reactive maintenance programme includes equipment and electrical checks.

All bedrooms are single and some have full ensuite facilities. Communal ablution facilities are available. Residents' rooms have adequate personal space provided. There are two lounges and two dining areas available. External areas are available for sitting and shading is provided.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All personal laundry is washed on site. Cleaning and laundry systems, including appropriate monitoring systems, are used to evaluate the effectiveness of these services.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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The organisation has processes in place for determining safe and appropriate restraint and enabler use. The facility is a secure unit, and on the day of audit there were no residents requiring the use of restraints or enablers. The three rest home residents' who have requested to remain in the facility, despite it being a secure facility are able to independently exit the facility at any time.

Infection prevention and control

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

There is an infection prevention and control programme for which external advice and support was sought; this is reviewed annually. An infection control nurse 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 was 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.

| 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) |
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| Standards | 0 | 41 | 0 | 3 | 1 | 0 | 0 |
| Criteria | 0 | 89 | 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) |
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| Standards | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 0 | 0 | 0 | 0 |

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is provided to staff during their induction to the service and through the ongoing education programme. The Health and Disability Advocate has provided education on the Code.</p> <p>Staff confirmed their understanding of the Code. Examples were provided on ways the Code was implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.</p> <p>The information pack provided to residents and family on entry includes how to make a complaint, code of rights pamphlet and advocacy information.</p> <p>Care staff were observed displaying respectful attitudes towards residents and family members.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided</p> | FA | <p>The informed consent policy guides staff in relation to informed consent. Resident files included documented consent relating to general consent. Consent is also obtained on an as-required basis, such as for flu' vaccinations. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs</p> |

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| <p>with the information they need to make informed choices and give informed consent.</p> | | <p>and these were reviewed on resident's files, where available.</p> <p>Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with their relative and consulted when treatment changes were being considered.</p> |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | <p>FA</p> | <p>Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. Staff education records confirmed this. Staff demonstrated their understanding of the advocacy service and contact details for the service are readily available.</p> <p>The nationwide advocate details are displayed along with advocacy information brochures. Admission / pre-admission information includes advocacy, complaints and the Code of Rights.</p> <p>Residents and family members confirmed their awareness of the advocacy service and how to access this, although all stated they would feel comfortable about approaching the facility manager should they have any concerns.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | <p>FA</p> | <p>Residents are encouraged to maintain links with the community interests and visit with their families. The service's activities programme includes regular outings in the facility's van.</p> <p>The service welcomes visitors, and has unrestricted visiting hours. Family members advised they feel welcome when they visit. Residents reported they are supported by staff to access health care services outside of the facility.</p> <p>Residents and family members confirmed they can have access to visitors of their choice, and confirmed they are supported to access services within the community.</p> <p>Residents' files demonstrated that progress notes and the content of care plans include regular outings and appointments.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>FA</p> | <p>The facility manager, with the support of the general manager, is responsible for management of complaints. There are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes complaints received verbally as well as in writing.</p> <p>The general manager advised there has been one complaint made to the Health and Disability Commissioner (HDC) since the last audit. This complaint related to 'care' provided to a resident</p> |

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| | | <p>and the HDC letter advising their investigation was closed and they would not be taking any further action was sighted. The general manager advised there have been no complaint investigations by the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. There has been one complaint received from the District Health Board (DHB) relating to a resident leaving the facility without supervision that was worked through (see link 1.2.4).</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and family interviewed demonstrate an understanding and awareness of these processes.</p> <p>The complaint process is readily accessible and/or displayed. The quality and staff meeting minutes provided evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via their staff meetings.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>The Code of Rights and information on the advocacy service were available and displayed at the facility. This information is provided as part of the pre-admission and information packs. Residents and family members confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service. Residents and family also confirmed explanations regarding their rights occurred on admission. They also confirmed care staff provided them with information on their rights any time they have had a query.</p> <p>Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.</p> <p>Residents confirmed they had access to an advocate if needed. Residents' meetings are held monthly and the meeting minutes indicated residents are aware of their rights. Residents and family stated they would feel comfortable raising issues with any of the staff.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and</p> | <p>FA</p> | <p>Staff were observed treating residents with respect during this audit. This was confirmed by residents and family members and during review of satisfaction surveys. Residents were addressed by their preferred names.</p> <p>Staff understand the policy relating to abuse and neglect. Staff gave examples of what would constitute abuse and neglect and the actions they would take if they suspected this. Education on abuse and neglect has been provided for staff. Staff employment contracts contain information</p> |

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| <p>independence.</p> | | <p>relating to expected standards of behaviour, and the disciplinary actions that would ensue should those standards not be met.</p> <p>All bedrooms provide single accommodation. Staff were observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Care staff demonstrated an awareness of residents' rights and the maintenance of professional boundaries.</p> <p>Activities in the community are encouraged and the general manager and facility manager advised the residents attend community events as able. Church services are held on site monthly.</p> <p>The residents' records included documentation relating to individual cultural, religious and social needs, values and beliefs that had then been incorporated into their individual care plan; although interventions are not consistently documented to meet the resident's cultural needs (see criterion 1.3.6.1). The residents care plans included information on the resident's abilities, and strategies to maintain/maximise their independence. These plans had been developed in conjunction with the resident and/or their family.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>There is a Māori health plan that includes the three principles of the Treaty of Waitangi: Partnership, Participation and Protection. The Māori health plan describes the incorporation of the holistic view of Māori health into the delivery of services (whānau, Hinengaro, Tinana and Wairua). The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan.</p> <p>There is currently one resident who identifies as Māori. The facility manager identifies as Māori and speaks Te Reo Māori with this resident. Additional access to Māori support and advocacy services is available if required from the local Māori Women's' Welfare League.</p> <p>Cultural aspects of care are incorporated in to this resident's care, although specific interventions to meet their cultural needs are not clearly documented in their care plan (see criterion 1.3.6.1) Whānau are as involved in the care of Māori residents as they are able to be.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect</p> | <p>FA</p> | <p>The individual preferences, values and beliefs of residents were included in the care plans reviewed. These care plans did not include documented interventions to ensure resident's cultural needs are met although staff could describe the interventions and these were observed during this audit (see criterion 1.3.6.1). Residents and family members advised they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs</p> |

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| <p>their ethnic, cultural, spiritual values, and beliefs.</p> | | <p>were respected.</p> <p>Care staff demonstrated an understanding of cultural safety in relation to care. Staff also demonstrated processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>Policies and procedures outline the safeguards to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Staff files included copies of a code of conduct that all staff are required to adhere to. The code of conduct also addresses any conflict of interest issues including the accepting of gifts and personal transactions with residents. Expected staff practice is also outlined in job descriptions and employment agreements, which were reviewed on staff files.</p> <p>A review of the accident/incident reporting documentation, complaints register and interview of the general manager indicated there have been no allegations made by residents or family alleging unacceptable behaviour by staff members.</p> <p>Residents and family reported that staff maintain appropriate professional boundaries. Staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>The service has established professional networks to help ensure residents receive services of an appropriate standard, including specialist services at the local District Health Board (DHB). Clinical policies, which are current and reflect best practice, are available to guide staff in care delivery. The facility manager is supported to attend external education sessions.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>A review of accident/incident reporting system demonstrated timely and open communication with residents/family members. Communication with family members is recorded in the progress notes. Family members expressed satisfaction with how well they were kept informed about any change to the resident's condition and their involvement in resident care planning and six monthly reviews of resident care. Resident meetings are held monthly and minutes were reviewed.</p> <p>The facility manager advised that interpreter services are able to be accessed from the staff, community and District Health Board (DHB) if required. This information is also provided to</p> |

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| | | <p>residents/families as part of the information/admission pack.</p> <p>The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Admission agreements were reviewed and this was clearly communicated in each agreement.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>MV and CD Hodson Partnership is the governing body and are responsible for the service provided at Westella Homestead (Westella). MV and CD Hodson Partnership have contracted the management of Westella to Dalcam Healthcare Limited (Dalcam). The general manager for Dalcam was interviewed and advised they report monthly via formal reports to one of the directors of Dalcam, who is also one of the partners of MV and CD Hodson Partnership.</p> <p>The organisation has a documented strategic plan for the period 2014 to 2019 as well as a business plan dated March 2016 and a quality plan and a risk management plan. The mission statement, vision, values and an organisational chart were reviewed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>A new facility manager, who is an experienced registered nurse, has been appointed since the last audit. The facility manager is responsible for the day-to-day management of the facility. The facility manager is also responsible for oversight of clinical care provided and is supported by two registered nurses. There is a registered nurse on site seven days a week.</p> <p>The personal files for the facility manager and the registered nurses confirmed all three have current practising certificates, job descriptions and evidence of ongoing education.</p> <p>Westella is currently certified to provide rest home care (dementia). The service provider is transitioning from rest home and dementia level care to dementia level care only. There were three residents assessed as requiring rest home level care during this audit and all have consented to being in a secure environment. These residents report they are able to leave the facility if they wish. Twenty two of the residents were assessed as requiring dementia level care and two of these residents are aged less than 65 years.</p> <p>The service provider has contracts with the District Health Board (DHB) to provide aged related residential care (rest home dementia), respite and day care services, and long term support - chronic health conditions.</p> |
| <p>Standard 1.2.2: Service Management</p> | FA | <p>Appropriate systems are in place to ensure the day-to-day operation of the service continues</p> |

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| <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | | <p>should the facility manager be absent. The registered nurse who works Monday to Friday, in the absence of the facility manager, assumes the clinical leadership role, supported by the general manager as well as registered nurses from a nearby sister facility.</p> <p>Services provided meet the specific needs of the resident groups within the facility.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>The quality improvement plan is used to guide the quality programme and includes quality goals and objectives, a risk management strategy and a risk management plan. The facility manager is responsible for ensuring the organisations quality and risk management systems are maintained.</p> <p>The internal audits completed in 2015 and 2016 were reviewed during this audit, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. The health and safety manual included relevant policies and procedures.</p> <p>Monthly staff/quality and resident meetings are held and meeting minutes are available for review by staff. Meeting minutes provided evidence of reporting / feedback on internal audits completed and various clinical indicators.</p> <p>Clinical indicators and quality improvement data is recorded on an electronic database as well as on various register and forms. Quality improvement data is being collected, collated, analysed and reported. Quality improvement data reviewed, including adverse event reports, internal audits and meeting minutes provided evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed.</p> <p>Relevant standards were identified and included in the policies and procedures manuals. Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control. Staff confirmed they are advised of updated policies and that policies and procedures provide appropriate guidance for the service delivery.</p> <p>Health & Safety policies and procedures are available and staff are aware of, and reported, hazards at the facility when this is required. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.</p> |

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| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>Adverse, unplanned or untoward events are documented on an register. The registered nurse (RN) reported they are advised of all adverse events where there is an injury to a resident. They advise an RN undertakes an assessment of these residents. The assessment includes neurological observations for all unwitnessed falls and for injuries resulting in head wounds.</p> <p>Adverse events are collated and graphs of incidents and accidents are generated monthly. The facility manager writes a narrative report that includes an analysis of these events which is then presented at the monthly quality and staff meetings. Minutes of meetings and graphs evidenced reporting on the number and type of incidents/accidents.</p> <p>The general manager advised they notify the Ministry of Health and District Health Board of all instances of residents who leave the site without support/supervision. They also advised that there have been six instances where residents have left the facility since January 2015.</p> <p>There is an open disclosure policy. Communication with family and general practitioner (GP) following adverse events and if there is any change in the resident's condition is recorded in residents' records. Family members and the GP interviewed confirmed they are notified in a timely manner.</p> <p>Staff confirmed they are made aware of their responsibilities for completion of adverse events. Staff also confirmed they are recording accidents and incidents on the database.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>PA Low</p> | <p>Policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. Staff files included employment agreements, reference checks, police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.</p> <p>The facility manager has a background in education and is responsible for the in-service education programme. The education planners for 2015 - 2016 were reviewed and education is provided at least monthly. Staff also complete online learning modules each month. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided and staff attendance is high. Improvements are required with the education provided as there is no evidence that pressure injury prevention management and wound care education has been provided. A suite of competency assessment questionnaires are completed including for medication management and restraint. The facility manager and the two registered nurses have the required interRAI assessment training and competencies.</p> |

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| | | <p>All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules, including dementia specific. Staff are also supported to complete education via external education providers.</p> <p>An appraisal schedule is in place and current staff appraisals were in the staff files.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of services provided.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>There is a documented rationale for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided Monday to Sunday inclusive between 8.30am and 4.30pm. Additional RN support is available 24 hours a day from a nearby sister facility. The minimum amount of staff on duty is between 11.30pm and 7.30am and consists of two caregivers.</p> <p>Care staff reported there is adequate staff available and that they are able to get through their work. Residents and family reported staff provide them with adequate care.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>Resident related information is kept in an electronic database as well as hard-copy and is maintained securely. Archived material is also kept securely and easily retrievable.</p> <p>All components of the residents' records include the resident's unique identifier. The clinical records were well organised and integrated, including information such as medical notes, assessment information and reports from other health professionals.</p> <p>Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the staff in the progress notes clearly identify the name of the person making the entry.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been</p> | FA | <p>When the need for service had been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner. Specialist referral to the service is confirmed: The Enduring power of attorney (EPOA) of each resident requiring specialised care, has consented to the resident being admitted.</p> <p>Information about the service includes the specific dementia care services provided, including the</p> |

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| identified. | | <p>use of technology to facilitate management of residents with dementia in an environment of minimal restrictions and risk. Full details of the services location and hours, how the service is accessed and the process if a resident requires a change in the care provided, is also included.</p> <p>Files reviewed contained completed assessments.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | FA | <p>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 recorded in the progress notes.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | FA | <p>The medication management policy is comprehensive and identifies all aspects of medicine management using an electronic medication management system.</p> <p>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. All staff who administer medicines are competent to perform the function they manage.</p> <p>Controlled drugs are stored in a separate locked cupboard; however there were no controlled drugs in use or on site on the day of audit. The controlled drug register evidences accurate records.</p> <p>The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>The GP's authorises electronically the commencement and discontinuation of medicines. The three monthly GP review is recorded (refer 1.3.3.3).</p> <p>There are no residents who self-administer their medications.</p> <p>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 of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are not used. Any as required (PRN) medication administered requires electronic authorisation on the resident's medication chart. PRN medication requests include indications for use.</p> |

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| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>PA Low</p> | <p>The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietician's documented July-2015 assessment of the planned menu.</p> <p>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, and food is available at all times to meet residents' needs.</p> <p>Food procurement, production, transportation, delivery and disposal comply with current legislation and guidelines, however some aspects of food preparation and storage, requires improvement.</p> <p>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 however there is no documented verification of compliance.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.</p> <p>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.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | <p>FA</p> | <p>Interview with the facility manager 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.</p> |
| <p>Standard 1.3.4: Assessment Consumers' needs, support</p> | <p>FA</p> | <p>On admission, residents have their needs identified through a variety of information sources that includes the Needs Assessment and Service Coordination (NASC) agency, other service providers involved with the resident, the resident, family/whanau and on-site assessments using</p> |

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| <p>requirements, and preferences are gathered and recorded in a timely manner.</p> | | <p>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 or the whanau room with the resident and/or family/whanau present where possible</p> <p>Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. A medical assessment is undertaken within 48 hours of admission and reviewed as a resident's condition changes, or three monthly (refer 1.3.3.3).</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>FA</p> | <p>The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support the resident needs to meet their goals and desired outcomes. Behaviour management plans included triggers and interventions to redirect, de-escalate or manage challenging behaviours.</p> <p>Care plans evidence service integration with progress notes, activities notes and medical and allied health professionals' notations clearly documented, informative and relevant. Any change in care required is documented and verbally passed on to those concerned.</p> <p>Care plans are evaluated six monthly (refer 1.3.6.1) or more frequently as the resident's condition dictates. Interviews and documentation verified resident and family/whanau involvement.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>PA Moderate</p> | <p>Observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes. However documentation in the lifestyle care plan did not always include the detailed interventions required to meet some residents assessed needs, desired outcomes or goals.</p> <p>Short term care plans were initiated for short term or acute events and residents who experience un-observed falls have neurological observations completed. Documentation and observations demonstrated that consultation and liaison is occurring with other services. Services are delivered in a manner that supports the resident to maintain strengths and live safely in a secure environment.</p> <p>Residents and family/whanau members expressed satisfaction with the care provided.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p> |

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| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an holistic 24/7 activities programme that is meaningful to the residents. The activities reflect the skills, strengths and the interests of the residents. Interviews with residents and observations confirm they participate and enjoy activities. The diversional therapist (DT) and an assistant works 40 hours per week, providing activities meeting the needs and goals of residents, including two residents who are under the age of 65.</p> <p>The services review of the residents' activity levels was a factor in determining the hours the residents required involvement in meaningful activity. Interviews, observation and documentation evidences the modified activities roster, have residents involved in activities during times of previous unrest. This has provided an alternative way for residents to expend energy and reduced the episodes of challenging behaviours often associated with residents with dementia.</p> <p>Written activities are planned and displayed for residents and family to see. Each resident file has an activities plan, attendance record and a diversional therapy evaluation sheet completed for the resident. Activities are reviewed six monthly, sighted reviewed activity plans for resident files reviewed during the on-site audit. Activity goals include physical, intellectual, cultural and spiritual needs of residents. Outings take place and residents have signed consents for going on outings, on record. Residents were observed playing cards, gardening, playing pool, wandering in the garden and participating in physical exercises during the on-site audit.</p> <p>A residents' meeting is held monthly. 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.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>Resident care is reviewed on each shift and reported in the progress notes. If any change is noted it is reported to the RN.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN in conjunction with family, GP and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan (refer 1.3.6.1).</p> <p>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. Interviews, verified residents and family/whanau are included and informed of all</p> |

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| | | changes. |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>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 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. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>Documented processes are in place for the management of waste and hazardous substances including specific labelling requirements. Material safety data sheets have been provided by the chemical representative and are available and accessible for staff. Staff have received education on chemical safety as part of their in-service education programme. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>Hazardous substances were correctly labelled and the containers were appropriate for the contents. Protective clothing and equipment is provided and being used by staff.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>A current building warrant of fitness is displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. A proactive and reactive maintenance programme is in place that ensures buildings; plant and equipment are maintained to an adequate standard. The maintenance person was interviewed and review of the maintenance records confirmed this. The testing and tagging of equipment and calibration of bio medical equipment is current.</p> <p>The entire site is secured by electronic gates with security cameras and high fences. Residents are able to wander freely throughout the facility and grounds. GPS tracking is used for residents who have been identified with dementia related wandering. The external areas are safely maintained and are appropriate to the resident groups and setting. Residents are protected from risks associated with being outside (eg, provision of adequate and appropriate seating; provision of shade; and ensuring a safe area is available for recreation or evacuation purposes).</p> <p>Care staff confirmed they have access to appropriate equipment. Equipment is checked before</p> |

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| | | <p>use and staff are assessed as competent to use any equipment.</p> <p>Residents confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>Some bedrooms have full ensuite facilities and some have a wash hand basin. There are adequate numbers of accessible communal showers, toilets and hand basins for residents. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are maintained at a safe temperature.</p> <p>Communal toilets and showers have a system that indicates if it they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | <p>All bedrooms provide single accommodation. All rooms were personalised to varying degrees. Bedrooms are large enough to provide personal space for residents, and allow staff and equipment to move around safely.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>Adequate access is provided to the lounges and dining areas. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the</p> | FA | <p>Cleaning, laundry and safe storage and use of chemicals / poisons policies and procedures are available.</p> <p>All personal laundry is washed on site. All bedding and towels are washed off site by an external contractor. There are appropriate storage areas for soiled linen waiting for collection by the external contractor.</p> |

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| <p>service is being provided.</p> | | <p>Care staff are responsible for laundry and they described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner described cleaning processes.</p> <p>Safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required. Chemicals were labelled and stored safely within these areas. Chemical safety data sheets or equivalent were available. Appropriate facilities exist for the disposal of soiled water/waste (i.e., sluice room), convenient hand washing facilities are available and hygiene standards are maintained in storage areas.</p> <p>Residents and family stated they were satisfied with the cleaning and laundry service and this finding was confirmed during review of the satisfaction survey questionnaires.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | <p>FA</p> | <p>There are documented systems in place for essential, emergency and security services. There is a New Zealand Fire Service letter dated 6 August 2005 advising approval of fire evacuation scheme. Fire safety education, including a trial evacuation, was held on 14 April 2016.</p> <p>Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.</p> <p>Information in relation to emergency and security situations is available and displayed for staff and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets and cell phones.</p> <p>There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident groups and setting. Call bells are accessible/within reach and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate</p> | <p>FA</p> | <p>Procedures are in place to ensure the service responds to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation,</p> |

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| natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | | and an environment that is maintained at a safe and comfortable temperature. Environmental temperatures are monitored and recorded monthly. |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The infection prevention and control policy reflects the requirements of the infection prevention and control standard. The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme.</p> <p>The infection control programme, reviewed annually, establishes, maintains and monitors procedures covering infection control practices. The infection control practices are guided by the infection control manual in conjunction with the public health advisor at Mid Central Health.</p> <p>It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted. Reporting lines for infection control management are clearly defined.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | <p>The infection control nurse (ICN) is responsible for implementing the infection control programme and reports directly to the facility manager, who reports to the general manager. A position description is included in the infection control (IC) programme.</p> <p>The ICN and observation verified there are enough human, physical and information resources to implement the infection control programme. Training records sighted and interview verified the ICN attends regular ongoing training.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>The infection control programme includes policies and procedures. Policies are current and signed off by ICN in conjunction with input from the DHB.</p> <p>Staff interviewed verify knowledge of infection control policies. Staff are observed to be compliant with generalised infection control practices.</p> |

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| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | <p>FA</p> | <p>Interviews, observation and documentation verify staff have received education in infection control and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectations.</p> <p>Resident education occurs in a manner that recognises and meets the residents' and the families' communication style, as verified by resident and family interviews.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | <p>FA</p> | <p>In line with Health and Disability Services Standards (HDSS) surveillance of infections is occurring and is the responsibility of the infection control nurse (ICN).</p> <p>Daily incidents of infections and the required management plan are presented daily at handover, and via electronic alerts, to ensure early interventions. Surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions.</p> <p>Incidents of infections are presented at the quality meetings and any ongoing corrective actions discussed and presented to staff at staff meetings, as evidenced by meeting records, infection control records and staff interviews. The service participates in internal benchmarking within the organisations other facilities as well as external benchmarking with similar service. Surveillance data evidences incidents of infections are low.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. The service demonstrates that the use of restraint is actively minimised. The residents are free to wander round the gardens. There are no locked doors and residents can enter or leave the building as they feel like. There is no evidence of any residents using physical restraints or enablers. Interviews with staff, residents and their family members confirm physical restraint and enablers are not being used in the facility.</p> <p>The three residents assessed as requiring rest home care requested to stay at the facility after rest home level of care changed to dementia level of care. These residents have consented to being cared for in a designated secure unit (refer 1.3.3), as they did not want to leave the facility. Review of these residents' files evidenced written consent records, requesting their desire to stay at the facility despite it being secure. Consents are reviewed yearly.</p> <p>Documentation, observations and interviews verifies each of the three rest home residents have the means to independently exit the unit at any time and the provider does not intentionally restrict the residents normal access to the environment.</p> |

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Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | PA Low | Two of the registered nurses (RN) stated they have attended pressure injury prevention and wound management education but there is no documented evidence on their files to support this. The RNs are enrolled to attend a wound, skin and pressure area management seminar in mid-June 2016. | Pressure injury prevention management and wound care education has not been provided as part of the education programme. | <p>Provide documented evidence that pressure injury prevention management and wound care education has been provided</p> <p>60 days</p> |
| <p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery,</p> | PA Low | Shelves in the pantry are chipped and expose bare wood that is permeable to spills and difficult to keep clean. Containers of decanted goods have no dates to indicate the items use by date. Cooked meat temperatures are not monitored to ensure the correct temperature has been reached and meat has been cooked properly. The cleaning schedule does not include all items requiring cleaning | Some aspects of food preparation and storage is not consistent with current legislation and | All aspects of food procurement, production, preparation, storage, transportation, |

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| and disposal comply with current legislation, and guidelines. | | on a regular basis, nor verification of compliance with the cleaning schedule. | guidelines. | delivery and disposal comply with current legislation and guidelines. 60 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 files reviewed evidenced GPs reviewing residents three monthly although there is no documented evidence to verify the resident was stable and not requiring monthly review. An interview with the GP, did however verify the residents were stable and did not require to be attended to monthly. Ten electronic medication files reviewed, identified four not having been reviewed in the last three months. Evidence verified the resident had been seen by the GP, three monthly. | The general practitioners review of residents and medications are not within the required timeframes. | Each stage of service provision is within the required timeframes. 60 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 | Files reviewed identified two residents with diverse cultural needs having no interventions detailing how these are to be addressed. A resident with a wound has no detailed management plan as to how this is to be managed. Two residents with an increase in their falls risk, have reference to this in the evaluation; however no update on the intervention required to manage the increased risk. | Documented interventions are not always consistent with residents assessed needs and evaluations. | Interventions are consistent with residents assessed needs. 60 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.