

Dementia Specialists Limited - Brooklands Rest Home

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](#).

The specifics of this audit included:

Legal entity: Dementia Specialists Limited

Premises audited: Brooklands Rest home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 23 June 2016 End date: 24 June 2016

Proposed changes to current services (if any): This is a for a change of ownership.

Total beds occupied across all premises included in the audit on the first day of the audit: 15

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

Brooklands Rest Home is a 23 bed facility. It is located in New Plymouth and is one of 11 Heritage Lifecare facilities. This provisional audit was undertaken to establish the prospective owner's preparedness to provide a health and disability service and the current level of conformity with the required standards. The proposed settlement date is the 9 August 2016 with takeover occurring on the 10 August 2016.

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 and residents' files and observations. Interviews occurred with residents, families/whānau, facility management and the existing owner's representative (quality and compliance manager), staff and the prospective owner/director.

The existing services had no areas identified for improvement in the previous audit. Seven areas identified for improvement in this audit relate to complaints management, staff annual appraisals being overdue, management of archived records, not all 'interRAI'

assessments being up to date and no current assessment for one hospital level care resident, medication management systems, building and equipment compliance and education for the infection control nurse.

The prospective provider has previous aged care management experience and will maintain the current policies, procedures and systems for the initial takeover period. Staff, residents and family/whānau are aware of the upcoming change of ownership as confirmed during interviews.

Consumer rights

The service has policies and systems in place to ensure that residents' rights are respected and that residents are free from discrimination and/or abuse and neglect. Staff receive regular training to ensure they respect the independence, personal privacy, individual needs and dignity of residents. The services provided to residents are of an appropriate standard, and during the audit visits residents were observed to be treated in a pleasant and professional manner. Residents and their families reported their satisfaction with the services provided and of the open communication with staff.

The perspective owner/director understands the complaints process. The facility manager confirms that all complaints have been fully resolved in house.

Organisational management

The service has a business and quality plan in place. The organisation's current mission statement, goals and philosophy will be continued by the prospective owner/director to ensure residents' needs continue to be met. The prospective owner/director has drawn up a new governance and management structure which was sighted. There was no documented transition plan as the prospective owner/director stated that no service delivery changes will be made in the immediate future under the new ownership. The existing policies and procedures will be maintained along with the quality and risk management systems. Safe staffing levels will be maintained with daily monitoring and review of occupancy and resident's needs.

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. The prospective owner/director understood human resources requirements.

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

Continuum of service delivery

Registered Nurses are on duty Monday to Friday and on call weekends. There are well-established processes in place to guide continuity of care, such as the updating of residents' progress notes each shift, and written and verbal handover of information between shifts.

Care plans are individualised based on a comprehensive and integrated range of clinical information and include input from residents and families. Residents' progress towards achieving identified goals is evaluated on a regular basis, and more frequently when residents' needs change.

A staff member with responsibility for activities manages the residents' activity programme, which offers residents a variety of individual and group activities. Residents are encouraged to maintain their links with the community. A community van is available for outings. The new owner/director will purchase a facility van upon settlement. Residents' meetings are held monthly.

Medications are administered by senior caregivers who have demonstrated their competency in relation to medicines management.

The kitchen was well organised and maintained in a clean and hygienic manner. Staff have the appropriate food safety qualifications. There is a systematic and comprehensive approach to ensuring that all aspects of food services are well managed, and that resident's individual needs were being met.

Safe and appropriate environment

Services are provided in an environment that is appropriate to rest home level care. There are amenities that meet residents' needs and 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. Reactive maintenance is documented. The prospective owner/director is aware of the maintenance improvements identified during this audit.

Systems are in place for essential, emergency and security services. Six monthly emergency evacuation drills have occurred.

All residents have easy access to outdoor areas with appropriate seating.

The prospective owner/director 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. Policy identifies that enablers are voluntary. The environment is restraint and enabler free at the time of audit and this was confirmed in documentation sighted.

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 and understood.

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

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 | 38 | 0 | 6 | 1 | 0 | 0 |
| Criteria | 0 | 85 | 0 | 6 | 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>Policy documents, the staff orientation programme, in-service training records, education programmes, interviews with staff, residents and their families, and satisfaction surveys verified the services provided complies with consumer rights legislation.</p> <p>Staff were observed to explain procedures, seek verbal acknowledgement for a procedure to proceed, protect residents' privacy, and address residents by their preferred name.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA | <p>Documentation, observation and interviews evidenced information was provided to make informed choices. Informed consent was understood and was included in the admission process. The resident, and where desired family/whānau, 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.</p> |

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| <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>Documentation, observation and interviews evidenced the service recognises and facilitates the rights of residents and their family/whanau to advocacy/support by persons of their choice. The facility had 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 interviewed were aware of their right to have support persons.</p> <p>At the time of admission to the service residents are given information on the Advocacy Service including contact details. Residents and family members confirmed their awareness of the Advocacy Service and how to access this. Staff demonstrated their understanding of the Advocacy Service, including contact details.</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 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 acknowledged residents' values and encourages the involvement of families/whanau in the provision of care. The activities programme actively supports community involvement.</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>PA Low</p> | <p>The service has a complaints register which shows how complaints processes are recorded and managed. Complaints are reported in the quality indicator data reported to head office monthly. The complaints register shows no complaints were made in 2016. However, the quality indicator data identifies there was one complaint made in March 2016. This is confirmed in the April 2016 staff meeting minutes. No details of the complaint or the follow up could be located on the days of audit.</p> <p>Staff, residents and family/whānau understand the complaints procedure and have access to complaints forms at all times. A copy of the complaints form is included in the welcome pack given to new residents and the process is discussed as part of the admission process. Management confirmed all complaints have been resolved in-house</p> |

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| | | since the previous audit |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>Residents were informed of their rights, as verified by interviews, observations and documentation. Information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service (Advocacy Service) was displayed and accessible to residents.</p> <p>Discussion, clarification and explanation on the Code and the Advocacy Service occurred at admission, followed by ongoing discussions/clarifications on an as-required basis. Legal advice was able to be sought on the admission agreement or any aspect of the service. Information was provided on the facility's range of costs and services.</p> <p>The prospective provider, during interview, was able to verify knowledge, understanding and awareness of obligations to adhere to the Code.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>Procedures were in place to ensure residents were 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 received services which treated them with respect and had regard for their dignity, privacy, sexuality, spirituality and independence. The privacy of resident information was maintained. All residents' clinical files were held in the nurses' station; personal information in administration files was stored securely. The privacy of residents' information was maintained during the verbal handover from one shift to the next.</p> <p>Staff demonstrated awareness and responsiveness to residents' needs. Staff were noted to knock on residents' doors before entering, address residents by their preferred name and ensured that residents' privacy was maintained during personal cares. The service's policy related to abuse and neglect was well understood by those staff interviewed.</p> <p>Residents and families interviewed confirmed that residents were treated respectfully at all times.</p> |

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| <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>Documentation was in place to guide staff practices to ensure residents' needs were met in a manner that respects and acknowledged their individual cultural, values and beliefs. Policy stated that this was to be identified upon entry as part of a resident's care planning process. The service recognised the relationship between iwi and the Crown and the principles of the Treaty of Waitangi (partnership, participation and protection). Whanau relationships and involvement in care was recognised.</p> <p>The District Health Board (DHB) supported the needs of Maori residents and would assist if required. There were no residents who identified as Maori at the time of audit.</p> <p>Staff received education in relation to cultural safety and the Treaty of Waitangi.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>Documentation, interviews and observation verified residents received and were 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 care plans of the resident and/or their family being involved in their development and ongoing evaluation.</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>Policy indicated that residents are to be free from all forms of discrimination, coercion, harassment and exploitations. Orientation/induction processes informed staff on the Code. The company's house rules, policies and procedures provide clear guidelines on professional boundaries and conduct, and informed staff about working within their professional boundaries.</p> <p>Interviews verified staff understanding. Residents felt safe and received a high standard of support and assistance and reported there was no</p> |

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| | | sign of harassment or discrimination. |
| Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard. | FA | The service encouraged good practice. Policies sighted were current, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies reflect current evidence based best practices which are monitored and evaluated at organisational and facility level. Evidence verified a range of opportunities was provided to enable staff to provide services of a high standard. |
| Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service had an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure was provided. Communication with relatives was documented in the residents' communication records and incident forms. Evidence was sighted of resident/family input into the care planning process. 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. Policy identified that interpreter services were available and offered to residents with English as a second language |
| 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 15 beds are occupied; 14 rest home level care, and one hospital level care. Management were advised to gain an updated assessment for the hospital level care resident as district health board approval was previously given in October 2010 when the resident was deemed as palliative. Refer comments in criteria 1.3.4. 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/director will use the current business planning processes until they are established in the business. They are aware that the direction and goals of the organisation need to be reviewed regularly and have developed a new governance structure which was sighted. The |

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| | | <p>new owner/director will employ a facility manager, clinical manager and business manager who will work at the facility at 3 days per week. Individual employment agreements have been offered to staff for these positions.</p> <p>The new owner/director has a health related background and has previously owned their own aged care facility. Their most recent role was working in the development of a specialist dementia care village. The planned takeover date is the 10 August 2016.</p> <p>Interviews with residents and family/whānau confirmed that their needs were met by the service. They confirmed they have been kept informed of the pending change of ownership.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | FA | <p>Currently during a temporary absence of the senior staff and/or management, staff are relocated from other like facilities owned by the organisation. For example, on the days of audit the registered nurse was on secondment to cover the interim clinical manager over a three-week period.</p> <p>The prospective owner/director stated they will ensure that there will always be staff on duty who are suitably qualified and experienced in the position they are covering.</p> <p>Staff have been offered new job contracts and the prospective owner is in the process of negotiating this process.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>The current service has a business plan and quality and risk processes in place which cover all aspects of service delivery. The quality planning process identifies site specific goals and objectives and the measures used to identify how the controls are effective or responsive to residents' needs. The prospective owner/director will operate using existing data. This includes gaining data for key components of service such as complaints management, restraint, infection control, health and safety and human resources management. Quality data collection and analysis occurs monthly and is reported and monitored at head office. Follow-up corrective actions are put in place to manage areas of concern or deficit.</p> |

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| | | <p>Senior staff confirm they understand the processes in place.</p> <p>Corrective actions are taken to improve services, such as those documented to reduce residents' falls and address medication errors. The prospective owner/director expects to be on-site at least three days a week to monitor all aspects of service delivery.</p> <p>The internal audit system is clearly documented and up to date as identified in documentation sighted. It is used to measure achievement against the quality and risk management plan. The prospective owner/director will continue to trend data against previously collected data.</p> <p>Current policies and procedures will remain in place and will be updated when the new management structure has been fully established. The use of the existing policies and procedures has been agreed as part of the purchase of the business. A rebranding exercise will occur once ownership changes hands.</p> <p>Actual and potential risks are identified and documented in the hazard register. Currently there has been one staff member nominated to undertake the role of health and safety officer and formalised education and training has yet to be arranged. This is identified in meeting minutes sighted. Health and safety matters are discussed at monthly staff meetings.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>Policy is implemented related to adverse events. The obligations in relation to essential notification reporting is understood and current management knows which regulatory bodies must be notified related to adverse event reporting. A section 31 report for a resident who wandered was sighted and public health notification of a recent outbreak of diarrhoea and vomiting was sighted.</p> <p>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 monthly staff meetings and reported and monitored at head office. All incident and accident forms sighted showed appropriate follow up actions had been taken.</p> |

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| | | <p>Family/whānau interviewed confirmed they are notified of any adverse, unplanned or untoward events at all times. This is also confirmed in documentation sighted in resident files.</p> <p>The prospective owner/director is conversant with legislative and compliance issues which may impact on the service and has undertaken due diligence.</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> | PA Low | <p>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/director does not intend to change employment processes. At the time of audit not all staff appraisals are up to date.</p> <p>There is a staff education plan in place for 2016. Education and training undertaken by staff 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. The new owner/operates intends to build upon the current education plan.</p> <p>Family/whanau and residents confirmed during interview that services were delivered in a caring and professional manner.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>The service 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 care staff are replaced for annual leave or sick leave. All shifts are covered by a staff member who holds a current first aid certificate.</p> <p>There are at least two caregivers on every shift. There is always a registered nurse on call. Caregivers undertake laundry as part of their</p> |

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| | | <p>daily tasks.</p> <p>There are dedicated cleaning staff Monday to Friday, maintenance for one hour per day and activities for three hours per day. It was noted that the activities person is not always replaced when sick. The facility manager confirmed activities are undertaken by caregivers as required.</p> <p>During interview staff reported that they have sufficient time and staff to complete their required duties.</p> <p>Safe staffing levels and skill mix will be maintained with daily monitoring and review off occupancy and resident's needs.</p> <p>Residents interviewed stated all their needs have been met in a timely manner.</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> | PA Low | <p>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) were used as the unique identifier on all residents' information sighted. All records were legible and the name and designation of the service provider was identifiable.</p> <p>Clinical notes are current and integrated with GP 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. 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.</p> <p>Archived records are being held on site in a secure room.</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</p> | FA | <p>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</p> |

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| <p>services has been identified.</p> | | <p>provided.</p> <p>The temporary relief clinical manager on the days of audit outlined the processes associated with service entry. When the need for service has been identified, it was planned, co-ordinated and delivered in a timely and appropriate manner. 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 had been assessed and confirmed by the Needs Assessment and Service Coordination (NASC) Service.</p> <p>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. Files reviewed contained completed assessments. Signed admission agreements meet contractual requirements.</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> | <p>FA</p> | <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 documented 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> | <p>PA Moderate</p> | <p>The medicine management system was observed on the day of audit. 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 have been assessed as competent to perform the function they manage.</p> <p>The 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.</p> <p>The records of temperature for the medicine fridge have readings documenting temperatures outside the recommended range. This had</p> |

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| | | <p>been attended to at the time.</p> <p>The GP's signature and dates are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart. Residents' allergy status is documented.</p> <p>The senior caregiver advised that medications are checked against the medication chart by a RN on arrival to the service; this was verified by documentation. 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 medications are returned to the pharmacy.</p> <p>A resident who self-administers an inhaler had appropriate processes in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the temporary relief clinical manager or interim clinical manager 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.</p> <p>Standing orders are not used.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>The food, fluid and nutritional requirements of the residents are provided in line with recognised nutritional guidelines for older people as verified by the dietitian's April-2016 documented 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, was sighted. There is an effective and systematic approach to ensuring that residents' weight are carefully monitored monthly and followed up when a concern arises.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and</p> |

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| | | <p>guidelines.</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 was sighted as was signed verification by the person responsible that this had been attended to.</p> <p>Evidence of resident satisfaction with meals was 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> | FA | <p>The temporary relief clinical manager interviewed confirmed the process 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 manner and in a format that was understood. Assistance is 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</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | PA Low | <p>As verified by observation, interviews and documentation, on admission, residents have their needs identified through a variety of information sources that include the NASC agency, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools.</p> <p>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.</p> <p>Over the next three weeks, the RN undertakes an 'interRAI' assessment, and other assessments as clinically indicated, which are reviewed six</p> |

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| | | <p>monthly or as needs, outcomes and goals of the resident change.</p> <p>A medical assessment is undertaken within 48 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. A multidisciplinary assessment is undertaken yearly.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Files reviewed evidenced all residents had an individualised care plan. The assessment findings in consultation with the resident and/or family/whanau, inform the care plan and assist in identifying the required support from care staff, to meet their goals and desired outcomes.</p> <p>Care plans evidenced 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 was documented and verbally passed on to those concerned.</p> <p>Care plans are evaluated three monthly or more frequently as the resident's condition dictates. Residents and families interviewed confirmed their participation in the development of care plans and their ongoing evaluation and review.</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> | FA | <p>Documentation, observations and interviews verified the provision of care to residents was consistent with residents' needs and desired outcomes (refer 1.3.3.3). The facility manager and the temporary relief clinical manager or interim clinical manager are on call 24 hours a day to provide support and guidance for care delivery staff. Well established processes are in place to ensure continuity of care. An attempt to interview any of the fourteen GPs who have residents at the facility was unsuccessful due to their unavailability. Residents and family/whanau members expressed satisfaction with the care provided.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs,</p> | FA | <p>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</p> |

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| <p>age, culture, and the setting of the service.</p> | | <p>develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted, provided activities that matches the skills, likes, dislikes and interests of the resident. The programme is delivered three hours per day for five days a week. The resident's individualised activity plans is reviewed as part of the care plan.</p> <p>Documentation, observation and interviews verifies 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 were developed according to the needs and preferences of the residents who choose to participate.</p> <p>A residents' meeting is held every two months. Meeting minutes and satisfaction surveys evidence the activities programme was discussed and that management were responsive to requests. Interviews verified feedback was sought on 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>Documentation, observations and interviews verified the RN is responsible for the evaluation of residents' 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.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals, occurs every six months or as residents' needs changed. Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</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 that residents and family/whanau were included and informed of all changes.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services</p> | <p>FA</p> | <p>Residents are supported to access or seek referral to other health and/or</p> |

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| <p>(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> | | <p>disability service providers. If the need for other non-urgent services is 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 RN 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.</p> <p>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> | <p>FA</p> | <p>The chemicals sighted were securely stored. Service providers follow policy to ensure safe and appropriate disposal of waste, including hazardous substance, that complies with all legislative and authority requirements. There are yellow sharps containers for the safe disposal of needles.</p> <p>During interview staff confirmed they can access personal protective clothing and equipment (PPE) such as disposal gloves and eye and face protection and aprons. The wearing of PPE was observed during audit.</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> | <p>PA Low</p> | <p>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 expires on 2 August 2016.</p> <p>Maintenance is undertaken by both internal maintenance and external contractors. Electrical safety test tags show this occurred in December 2016. Clinical equipment is tested and calibrated by an approved provider which last occurred in September 2015.</p> <p>The internal 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.</p> <p>The service documents regular maintenance which identifies day to day maintenance occurs upon request in a timely manner. One bedroom had</p> |

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| | | <p>a small hole in the wall behind the door and the grip rails in one bathroom are rusty and cannot be cleaned to meet infection control standards.</p> <p>There are easily accessed shaded outdoor areas with suitable furnishings for residents' use. An area underneath the facility is being used for storage of old equipment. The proposed owner/director was made aware of this on the day of audit and will negotiate the removal of this prior to takeover.</p> <p>Interviews with residents and family/whānau members confirmed the environment was suitable to meet their needs.</p> <p>The new owner/director intends to refurbish the interior of the facility but will not be making changes to the current building footprint in the near future. They are aware of the need to ensure compliance requirements related to any proposed future changes.</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> | <p>FA</p> | <p>There are hand basins in all residents' bedroom. Toilet and shower areas are centrally located in each of the three wings of the facility. There is a designated staff/visitor toilet.</p> <p>One bathroom has hand grip rails which are rusting refer comments in criterion 1.4.2.1. The maintenance person stated the work would be completed within the week to ensure it remains compliant with infection control standards. The prospective owner/director is aware of the repairs to be undertaken.</p> <p>Hot water temperatures are checked quarterly and kept within a safe range for an aged care facility. This is undertaken as part of the quality and risk monitoring requirements for the environmental checks.</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> | <p>FA</p> | <p>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. One bedroom had a small hole in the wall behind the door. Refer comments in criterion 1.4.2.1. The new owner/director is aware of</p> |

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| | | <p>this finding.</p> <p>Resident and family/whānau members interviewed did not identify any concerns related to personal bed space</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>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. Both lounge areas are used for activities.</p> <p>Residents and family/whānau voiced their satisfaction with the communal environment and confirmed there is adequate furnishings and areas to meet their needs.</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 service is being provided.</p> | FA | <p>There are secure storage areas for cleaning chemicals. Cleaning is undertaken five days a week by dedicated cleaning staff and spot cleaning is done by caregivers in the weekend. Tasks are clearly documented. The facility looked and smelled clean.</p> <p>The laundry has a designated clean and dirty area. Regular monthly checks of the chemicals used for laundry processes are documented by an external provider.</p> <p>The laundry operates seven days a week and is managed as part of the caregivers' daily tasks. The laundry is downstairs with the entrance door being kept locked at all times to prevent residents entering the area. The dryer and one of the two washing machines are leased. The new owner/director is aware of this.</p> <p>Residents and family/whānau members interviewed had no negative comments regarding cleaning and laundry services.</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> | FA | <p>Policies and procedures guide staff actions in the event of an emergency. There is an emergency plan which includes the approved fire evacuation scheme. A copy of where the assembly point is located should an evacuation be required is located on each resident's bedroom</p> |

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| | | <p>wall. Policy identifies that six monthly emergency education, training and fire drills have been maintained. This last occurred in March 2016 with no follow up actions required. Fire equipment was checked in May 2016 by an approved provider. Staff attend annual emergency education as confirmed in documentation sighted.</p> <p>All resident areas have smoke alarms and a sprinkler system to meet building code requirements. Emergency supplies and equipment include food and water and a civil defence kit which is checked quarterly.</p> <p>Staff are required to ensure all doors and windows are secured after hours. Staff and residents interviewed confirmed they feel safe at all times.</p> <p>There is a call bell system available for residents and staff to call for assistance if required.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | <p>FA</p> | <p>Areas used by residents are heated via electric heating and are ventilated by the opening of doors and windows. The areas used by residents have at least one opening window which allows ventilation and natural light. The facility is kept warm all year around as confirmed during staff, resident and family/whanau interviews.</p> |
| <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> | <p>FA</p> | <p>Interviews, observation and documentation verified the service has an infection prevention and control programme that is reviewed annually (last reviewed in November 2015) to maintain, monitor and establish new procedures covering infection control practices. The practices are guided by the infection control manual, with assistance from the DHB infection control nurse. It is the responsibility of all staff to adhere to the procedures and guidelines when carrying out all work practices.</p> <p>The interim clinical nurse manager was appointed the infection control nurse (ICN) in May 2016. Infection control matters, including surveillance results, are reported monthly at the quality/staff meetings and to the organisation's head office. Meeting minutes, monthly reports and quality indicator reports were sighted. There had been an outbreak in the past three months involving staff and residents and evidence was sighted of</p> |

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| | | <p>public health being notified.</p> <p>A sign at the main entrance to the facility requests anyone who is unwell not to enter the facility, and reminds visitors about the need for hand washing. Information for staff on how long they must stay away from work if they have been unwell is included in the infection control manual and provides guidance for staff.</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 ICN is responsible for implementing the infection control (IC) programme and reports directly to the facility manager. A position description is included in the IC programme.</p> <p>The ICN, recently appointed was unavailable for interview at time of audit. Training records confirm the ICN has not yet attended IC management training courses. Refer comments in criteria 3.4.1 The prospective owner has verified on interview the ICN will undergo appropriate training. If required, advice is able to be sought from a range of sources that include an IC manual, the IC nurse at the District Health Board, the Public Health unit, online resources and articles.</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>An IC policy/procedure manual guides infection prevention and control practices. These comply with relevant legislation and current accepted good practices. The manual is reviewed every two years, with the last review being undertaken in November 2015. Housekeeping and kitchen staff were observed to be compliant with IC practices. Care delivery staff were observed using hand-sanitizers on a regular basis and wearing disposable aprons and gloves as appropriate.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | PA Low | <p>Interviews, observation and documentation verified staff had received annual education in IC and prevention at orientation and during ongoing education sessions. The content of the training was documented and evaluated to ensure the content was relevant and understood. A record of attendance is maintained. Audits are undertaken to assess</p> |

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| | | <p>compliance with expectations.</p> <p>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 or the need for an increased fluid intake in warmer weather.</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> | FA | <p>Interviews, documentation and observation verified surveillance of infections (respiratory, skin, soft tissues, urinary tract, gastrointestinal and multidrug resistant infections) is occurring and is the responsibility of the ICN.</p> <p>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. No evidence was sighted of wound infections this year; however an increase in upper respiratory infections in residents with chronic respiratory conditions is noted in March, with analysis undertaken.</p> <p>Meeting minutes and interviews verified data is presented to the facility manager and quality/staff meetings and any ongoing corrective actions discussed and implemented.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>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, the service had no restraint or enablers in use.</p> <p>Staff have restraint and challenging behaviour management education bi-annually and they complete an annual competency questionnaire. Education was last presented in May and June 2015 respectively. This was confirmed in staff files reviewed. The facility manager is the restraint coordinator with a signed job description which identifies accountabilities and compliance measurement criteria.</p> |

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| | | The quality review for restraint was undertaken in February 2016 and identifies all policies, procedures and assessment forms are up to date and available should restraint ever be used. |
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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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | PA Low | The service has a complaints register in place. It shows the complaints made and actions taken to resolve them. It shows there were no complaints in 2016. No documentation could be located for one complaint discussed at the April staff meeting to identify that it has been closed off. The current facility manager is not aware of any outstanding complaints. | No complaints are documented in the complaints register for 2016. However, there is one complaint shown in the meeting minutes and on the quality indicator data 2016 presented from head office. No documentation could be found related to any complaints for 2016. The current nurse manager is not aware of any outstanding complaints so the complaint appears to be resolved. | <p>Ensure all complaints received are recorded in the complaints register to indicate all follow up taken.</p> <p>180 days</p> |
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective</p> | PA Low | There is a system in place to indicate annual education for staff. Attendance is recorded in each individual staff member's file. There is a system in place to indicate when annual appraisals are due. Not all annual appraisals are up to | Eight of 23 staff have overdue annual appraisal assessments. This does not comply with D17.7 f of the Age Related Residential Care Services Agreement. | Provide evidence that all staff appraisals are up to date. |

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| services to consumers. | | date. | | 180 days |
| <p>Criterion 1.2.9.1</p> <p>Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.</p> | PA Low | <p>Archived records were observed to be stored in boxes or filing cabinets in one of two locked and secure rooms. There is no cataloguing information available to indicate what each box or filing cabinet contained, and where specific records were located. Interviews with staff and the facility manager verified they were unaware of how to access specified archived records if required.</p> | <p>Resident information is collated, securely packaged and archived when the resident is no longer a resident of the service, however no consumer information management system is evident to enable retrieval of archived records if required.</p> | <p>Provide evidence that a system has been implemented to enable access to archived records when required.</p> <p>180 days</p> |
| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | PA Moderate | <p>The 'original' medication chart for each resident is updated when the GP undertakes a medication review. Any additions or alterations in the interim are made via a faxed copy of the medication chart, or a GP's prescription (following a visit to the GP's surgery). When administering medications, there are often numerous prescription requests to check, in addition to an original or faxed medication chart.</p> <p>A prescribed pro-re-nata (PRN) (as required) medication, on the original chart, is being dispensed by the pharmacy and administered daily as a regular medication. On review at audit, the GP had changed the prescription to regular, however, not updated this on the medication chart. This had gone undetected, at administration and reconciliation checks.</p> | <p>Not all aspects of the medicine management system meets best practice guidelines and ensures safe medicine management. When prescription medication is changed by the GP the medication chart is not updated.</p> | <p>Ensure there is a safe and accurate system for prescribing and administering medication.</p> <p>90 days</p> |

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| | | <p>A GP's prescription given to a resident following a visit to the GP, added a medication to be given. This was not recorded on the medication chart. Administration records showed this medication was not always administered as prescribed.</p> <p>The above findings were supported by documentation, observation and interviews.</p> | | |
| <p>Criterion 1.3.4.2</p> <p>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.</p> | PA Low | <p>Of the nine files reviewed, three files of long term residents contained no evidence of an interRAI assessment being completed, while another two were not up to date. No one onsite on the day of audit was able to access the facility's interRAI database to verify if this was correct. Other clinical assessments were up to date. On the days of audit, there was a temporary relieving clinical manager on site who was up to date and competent in InterRAI assessment. The interim clinical manager who was on leave, had completed the interRAI training in June 2014, however ongoing evidence of competency was not sighted. Care plans were reviewed and updated every three months or as residents' needs changed.</p> | <p>InterRAI assessments are not consistently undertaken or reviewed and updated.</p> <p>On the day of audit, files reviewed evidence the RN has undertaken an interRAI assessment within three weeks of admission, which is reviewed every six months however, this is not occurring consistently with every resident.</p> <p>The one hospital resident has not been reassessed since 2010. See comment in 1.2.1.</p> | <p>Provide evidence that all interRAI assessments are current and that the one hospital resident has been reassessed.</p> <p>180 days</p> |
| <p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with</p> | PA Low | <p>Documentation shows that regular monthly checks are completed to ensure all aspects required for the building warrant of fitness are maintained. Minor</p> | <p>The grab rails on the bathroom wall in wing B are rusty and cannot be cleaned to meet infection control standards. There is a hole in the wall behind the</p> | <p>Provide evidence that required maintenance is completed to comply</p> |

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| <p>legislation.</p> | | <p>maintenance repairs are undertaken by a nominated staff member. A small hole in the wall of one room and rusty grip rails in a bathroom were not shown on the maintenance requests.</p> <p>Electrical and medical equipment checking is undertaken at least annually.</p> <p>There are unused pieces of equipment, including portable gas bottles, stored in an outside area that is not used by residents.</p> | <p>door in room 22.</p> <p>The outdoor area at the back of the facility had unused equipment including two rusting gas bottles from the BBQ which need to be disposed of.</p> | <p>with legislative requirements.</p> <p>180 days</p> |
| <p>Criterion 3.4.1</p> <p>Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.</p> | <p>PA Low</p> | <p>Staff undertake regular education related to infection control. No evidence of the infection control nurse having updated training could be found. Refer comment in criteria 3.2</p> | <p>The infection control nurse does not have any updated training for the role.</p> | <p>Provide evidence that the infection control nurse has undertaken appropriate training.</p> <p>180 days</p> |

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.