

Heritage Lifecare Limited - Palms 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:	Heritage Lifecare Limited
Premises audited:	Palms Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 June 2016 End date: 16 June 2016
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	119

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

The Palms Rest Home is a 122 bed service for rest home and hospital level of care residents. The service consists of two separate buildings located within a retirement living complex. This provisional audit was undertaken to establish the prospective provider's preparedness to provide a health and disability service and the level of conformity with the required standards of the existing owner's services.

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

There are 10 areas for improvement identified at this audit. Six of these are related to the level of detailed documentation of corrective action plans, incident and accident reports, the exemption for three monthly medical reviews, assessments, care plans and the infection surveillance analysis. The other areas for improvement are related to ensuring the registered nurses conduct the

initial assessments and care plan, ensuring the medication fridge and resident records are securely stored, and some aspects of maintenance and storage.

The residents and family/whānau interviewed and the satisfaction survey results support that the service provision and manner in which the care is provided is a strength of the organisation.

The prospective provider owns other aged care services and demonstrated knowledge of the requirements for running an aged care service.

Consumer rights

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

There are no residents who identify as Maori at the time of audit, however appropriate policies, procedures and community connections ensure culturally appropriate support can be provided.

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

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

The service has a documented complaints management system which was implemented. There is one external complaint and one coroner's inquiry that are not yet finalised at the time of audit. One further external complaint has been closed off since the last audit.

Organisational management

The current owners and management have a business and quality plan in place. The philosophy, mission statement and vision of the organisation are documented. The prospective provider plans to continue with the current systems and has a transition plan for the oversight of the quality, compliance requirements and business supports.

The prospective provider's quality management plan was sighted. The current quality and risk system and processes support safe service delivery and include corrective actions. The corrective action plans were not always fully completed or evidenced that the actions implemented were effective, this includes action and risk assessments implemented after an incident/accident has occurred. The quality management system includes identification of hazards, staff education and training, an internal audit process, complaints management, data reporting of incidents/accidents and infections. The prospective provider does not intend to interrupt the quality system and internal auditing schedule, although will add an additional monthly clinical indicator reporting system and assist in making improvements to better document the implementation of the current systems.

The day to day operation of the facility is undertaken by clinical staff who are appropriately experienced and/or qualified. This allows residents' needs to be met in a safe and efficient manner.

Policies and procedures are developed by an external aged care consultant and the prospective provider intends to maintain these policies. The policies reflect current accepted practice.

The service implements the documented staffing levels and skill mix. The rosters record that there are adequate staff each shift to comply with contractual requirements. Human resources management and education processes are implemented that meet contractual requirements and the needs of the residents at rest home and hospital level of care. The prospective provider demonstrated a good understanding of human resources requirements and meeting contractual requirements and residents' needs. If changes are to be made these will also be reflective of safe staffing standards.

Residents' information is accurately recorded. Service providers used up to date and relevant residents' records.

Continuum of service delivery

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.

All residents' files sighted provide evidence that needs, goals and outcomes are identified and reviewed every six months. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

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

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

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

Safe and appropriate environment

The services consist of two separate buildings located within a wider retirement village complex. There are appropriate amenities to meet residents' needs and to facilitate independence. Residents, visitors and staff are protected from harm as a result of exposure to waste generated during service delivery. There are adequate toilets, showers, and handwashing facilities in each of the buildings.

Laundry and cleaning services are conducted onsite. Each of the rest home and hospital buildings have laundry, cleaning and sluice facilities. Overall the services are maintained to a high level to provide a clean, safe, secure environment that is appropriate to rest home and hospital level of care.

Documentation identifies that all processes are maintained to meet the requirements of the buildings warrant of fitness. Planned and reactive maintenance is documented. Systems are in place for essential, emergency and security services, including a disaster and emergency management plan.

All residents have access to outdoor areas with shaded areas. The residents in the upper level can access the grounds through lifts or stairs. There is a veranda off the upper level.

The prospective provider does not plan to make any major changes to services or environmental areas.

Restraint minimisation and safe practice

There are clear and comprehensive documented guidelines on the use of restraints and enablers and managing challenging behaviours. There were no residents using restraints or enablers at the time of the audit. Staff demonstrated a good understanding of restraint and enabler use and receive restraint minimisation education.

Infection prevention and control

There are appropriate systems in place for infection prevention and control. The infection control coordinators attend and provides regular staff education related to infection prevention and control. The documented policies and procedures for the prevention and control of infections are regularly reviewed. The infection control programme has been reviewed within the last year.

Surveillance for infections is conducted monthly, with external benchmarking three monthly. Results of surveillance are collected and collated. The prospective provider intends to keep the current policies, procedures and surveillance processes, with additional reporting of clinical indicators to the prospective provider's governance/quality team.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	36	0	7	2	0	0
Criteria	0	83	0	7	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Interviews with residents and family members of residents verified services provided complied with consumer rights legislation.</p> <p>Policy documents, staff orientation programme, in-service training records, education programmes, interviews with staff, and satisfaction surveys verified staff knowledge of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Clinical staff was 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>The informed consent policy describes all procedures to ensure the resident's right to be informed of all procedures undertaken.</p> <p>Documentation, observation and interviews evidenced information is provided to make informed choices. Informed consent is understood and is included in the admission process. The resident, and where desired family/whānau, are informed of changes in the resident's condition and</p>

		care needs, including medication changes. Residents' choices and decisions, including advanced directives, are recorded and acted on where valid.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Documentation, observation and interviews evidenced the service recognised and facilitated the rights of residents and their family/whanau to advocacy/support by persons of their choice. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilised appropriate community resources, both internally and externally. Residents and their families are 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. On interview, 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>	FA	<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 values and encouraged the involvement of families/whanau in the provision of care, and 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>	FA	<p>The sighted complaints policy and process complies with Right 10 of the Code. Complaints management is explained as part of the admission process and is included in the information given to new residents and family/whānau. Complaints management is included in new staff orientation and ongoing training.</p> <p>The complaints register identifies complaints have been managed within policy time frames. Since the last audit the service has had one external complaint investigated and satisfactorily closed off with no further actions</p>

		<p>required. There is one Coroner's inquiry and one other external complaint that have not yet been finalised. This audit included the review of a resident's file who had had an incident similar to the most recent complaint.</p> <p>The prospective provider's quality and compliance representative demonstrates understanding of consumers' right, including complaints management.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	<p>FA</p>	<p>Interviews, observations and documentation verified residents are informed of their rights. Information on the Health and Disability Commissioner's (HDC), the Code, and the Nationwide Health and Disability Advocacy Service (Advocacy Service) is displayed and accessible to residents.</p> <p>Discussion, clarification and explanation on the Code and the Advocacy Service occurred at admission. This is discussed by a registered nurse or the enrolled nurse at that time, and followed by discussions/clarifications on an as-required basis.</p> <p>Legal advice is able to be sought on the admission agreement or any aspect of the service. Information is provided on the facility's range of costs and services.</p> <p>The proposed new ownership group has wide experience in running other aged care facilities and is well aware of its obligation in relation to the Code and the Advocacy Service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>An interview with the General Manager identifies that procedures are in place to ensure residents are kept free from discrimination, harassment, abuse and neglect, including the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. Residents receive services which treat them with respect and have regard for their dignity, privacy, sexuality, spirituality and independence.</p> <p>The privacy of resident information is maintained in the rest home; however, this is not so in the hospital (refer 1.2.9.7). All residents'</p>

		<p>clinical files are held in the nurses' station and archived records are stored securely. The privacy of resident information is maintained during the verbal handover from one shift to the next.</p> <p>Staff demonstrated policy awareness and responsiveness to residents' needs. Staff were noted to knock on residents' doors before entering, addressing residents by their preferred name and ensuring that residents' privacy was maintained during personal cares. The service's policy related to abuse and neglect was well understood by those staff interviewed. Staff provided examples of what would constitute abuse and neglect and the actions they would take if they suspected this.</p> <p>Residents and families interviewed confirmed that residents were treated respectfully at all times.</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>Documentation is in place to guide staff practices to ensure residents' needs are met in a manner that respects and acknowledges their individual cultural, values and beliefs. The service recognises 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 are recognised. There were no residents who identified as Maori at the time of audit.</p> <p>Staff receive 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>The service maintains it is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of residents are valued and fostered within the service. Documentation, observations and interviews verifies they value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Spiritual needs are identified in the care plan; however, an assessment of residents' cultural needs is not sighted and not documented in the care plan (refer 1.3.4.2).</p> <p>Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic.</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 indicates that residents are to be free from all forms of discrimination, coercion, harassment and exploitations. Orientation/induction processes inform staff on the Code. The company's house rules, policies and procedures provide clear guidelines on professional boundaries and conduct and inform staff about working within their professional boundaries.</p> <p>Interviews verified staff understanding. Residents felt safe and received a high standard of support and assistance and reported there was no sign of harassment or discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages good practice, through its commitment to training and ensuring policies are current, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies reflected current evidence based best practices, which are monitored and evaluated at organisational and facility level.</p> <p>Evidence verified a range of opportunities is provided to enable staff to provide services of a high standard. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests.</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>Policy identified that interpreter services are available and offered to residents with English as a second language.</p> <p>The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided.</p> <p>Communication with relatives is documented in the residents' communication records and incident forms. Evidence was sighted of resident/family input into the care planning process. All family members interviewed stated they were informed in a timely manner about any</p>

		changes to the resident's status and verified an environment conducive to effective communication.
<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>The service has a maximum capacity of 122 residents in a 61 bed 'hospital' building and a 61 bed rest home building. Three of the rooms in the rest home can be double occupancy shared rooms. On the day of audit 119 beds were occupied, with 59 in the rest home building and 60 in the hospital building. The hospital building comprises of 23 beds solely at hospital level of care, with the remaining 38 rooms dual purpose that can have either rest home or hospital level of care. The rest home building is for rest home level of care residents only. There was no younger person under the age of 65 or resident receiving services under the hospital-medical contract at the time of audit. There is an additional day stay programme provided in a separate section of the rest home.</p> <p>The 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.</p> <p>The prospective provider is aware that the direction and goals of the organisation need to be reviewed regularly, as evidenced with interview with their representative. The quality policy statement identifies the mission of the organisation and the procedures undertaken to achieve the mission statement and commitment to provide safe and appropriate quality care. The prospective provider's transition plan records pre-acquisition, acquisition and post-acquisition time frames. The transition plan covers contracts, human resources management, finances, marketing, communications, information technology and the property. If changes to management are to occur, the new provider will ensure that there is an appropriately skilled and experienced person to perform the ongoing management of the service.</p> <p>The service is currently managed by a general manager, who has worked at the service for over 24 years and has managed the service since 2000. The general manger is a registered nurse (RN) with a current practising certificate and maintains ongoing skill, knowledge and education related to the management of an aged care service. The general manager's job description records their responsibilities and</p>

		<p>authorities for the overall management of the service. The general manager currently provides a monthly manager's report to the owners (who are both general practitioners). The prospective provider will add the addition of monthly reporting of both clinical and non-clinical indicators to the Heritage Lifecare governance team.</p> <p>The general manager is supported by a hospital manager (RN) and a rest home manager (enrolled nurse). All three managers have attended more than eight hours' education in the past 12 months related to management of aged care services.</p> <p>The residents and families have high praise for the care and services provided with the satisfaction survey recording an overall 97% satisfaction response.</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>During a temporary absence of the general manager, the rest home manager (EN) takes on the general manager's role, with support for clinical management by the hospital manager (RN). The general manager reports confidence in the staff's ability to take on the management role during temporary absences. The prospective provider does not intend to make any immediate changes to the management team. If any changes are to be made, the prospective provider reports these will be compliant with contractual requirements.</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>	PA Low	<p>Staff demonstrated an understanding of quality and risk management processes and confirmed their involvement with quality activities. Staff orientation and ongoing education includes self-directed learning packages on the quality and risk management systems.</p> <p>The service has a business plan and quality and risk process in place which covers all aspects of service delivery. Quality planning identifies generalised goals and objectives which have ongoing monitoring through the monthly manager's report and an internal auditing system. The managers' reports and data collection is reviewed and presented to the owners, at the managers' meeting, continuous quality improvement meetings, and are shared with staff at monthly staff meetings as identified in minutes sighted. Though the quality data is collected,</p>

		<p>analysis and evaluation of this is not always evident (refer to 3.5.7).</p> <p>Internal audits cover all aspects of service delivery and ensure work procedures and policies are followed. The results of internal audits are communicated to the owners and staff by reports and meetings. This included corrective actions plans, though these were not always fully completed.</p> <p>The prospective provider will review all systems and does not intend to interrupt the current internal auditing schedule. If any changes are to be made, these will reflect contractual requirements, principles of continuous quality improvements and the needs of the residents.</p> <p>Policies and procedures are developed by the service and reflect current accepted good practice. Staff have access to only the most current version of policies, with obsolete documents being archived. Any changes or newly introduced policies are shared with staff at the monthly staff meetings. Staff confirmed that they understand and implement documented quality and risk processes.</p> <p>There is a current risk register which identifies actual and potential risks for all levels of service. Minimisation strategies have been implemented as required. Staff education includes risk management processes. Interviews with staff confirmed their awareness and knowledge regarding the identification and reporting of hazards.</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>PA Low</p>	<p>The management team understood their obligations in relation to essential notification reporting and know which regulatory bodies must be notified. The service is aware of their responsibility to report stage 3 and above pressure injuries. Essential notification report forms were sighted. There are no legislative compliance issues that could affect the service.</p> <p>Staff interviewed stated they report and record all incidents and accidents. However, on the forms sampled it was not always evidenced what follow up actions were implemented. The monthly managers' reports included collation of the number and types of incidents.</p> <p>The prospective provider understands their responsibilities for essential notification and incident/accident reporting and intends to maintain the</p>

		current incident/accident reporting system.
<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>	FA	<p>The organisation implements human resources policies which describe good employment practices and reflect current legislative requirements. The employment, orientation and annual performance review process was confirmed during staff interviews and in the staff files sampled. The sample included a mix of clinical and non-clinical staff.</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for permanent and contracted staff. Annual practising certificates were sighted for those who required them. All staff have a current first aid qualification.</p> <p>Staff reported that they are supported to attend ongoing education. Training was provided on-site, off-site and with self-directed learning packages. Education records were maintained for the in-service and external education attended by staff. Education sighted covered all key components of service delivery. The service has nine staff who have completed the interRAI assessment training.</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 staffing and staff skills mix policy reflects the requirements for rest home and hospital level of care. Staff confirmed that staffing takes into consideration the assessed needs (acuity) of residents, associated roles, responsibilities and levels of experience of staff. The rest home and hospital services are in separate building and rostered independently of each other. There is at least one RN on duty at all times in the hospital, with at least two RNs on morning and afternoon duty. There is at least two staff on duty at all times in the rest home. The day stay programme is staffed separately from the rest home by two activities/diversional staff.</p> <p>The rest home staff and the RN on duty in the hospital (when more than one RN is on duty), can provide emergency assistance to people living in the retirement complex but only if the minimum staffing levels are maintained in both the rest home and hospital. There are additional afterhours and on call staff for the rest home and retirement complex.</p> <p>The organisation employs a sufficient number of administration, cooking,</p>

		<p>cleaning, laundry, maintenance and activities staff that meet the needs of the residents.</p> <p>The prospective provider reports that if any staff changes are to be made, these will reflect contractual requirements and safe staffing indicators.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>PA Moderate</p>	<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) are used as the unique identifier on all residents' information sighted. Clinical notes are current and integrated with GP and auxiliary staff notes. The files are kept secure in the rest home and are only accessible to authorised people; however, this is not always the case in the hospital.</p> <p>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 were being held on site in a secure room. These are catalogued for easy retrieval.</p>
<p>Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The managers of both the rest home and hospital outlined the processes associated with service entry. Prospective residents are provided with detailed information about the service. They are also advised they can only be admitted when their level of required care has been assessed and confirmed by the Needs Assessment and Service Coordination 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.</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 where possible. 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. All residents' transferring to a DHB facility, have a DHB generated form that ensures all the required information goes with the resident.</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 Low</p>	<p>All aspects of medication management are consistent with legislative requirements and safe practice guidelines, as evidenced by documentation, observation and interview.</p> <p>A safe system for medicine management was observed on the days of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Staff who administer medicines are competent to perform the function they manage.</p> <p>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 both the medicine fridges have readings documenting temperatures within the recommended range. The medication fridge in the rest home is not placed in a secure location.</p> <p>The medicine management system is electronic and the GPs authorisation is required for medication to become part of the system, and to be dispensed by the pharmacy. The GP review is recorded electronically on the medicine chart. Residents' allergy status was documented and medication administration records were complete.</p> <p>The registered nurse advised that medications in the hospital are checked against the medication chart by a RN on arrival to the service. In the rest home the medications are checked against the medication chart by two caregivers. All medications in the medication trolleys and stock cupboards were within current use dates. The date of first use of</p>

		<p>eye drops was recorded on those products currently in use. Surplus and expired medication is returned to the pharmacy.</p> <p>Residents' who self-administer their medicines have appropriate processes in place to ensure this is managed in a safe manner.</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 and management of any medication errors and compliance with this process was 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 January-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, is sighted.</p> <p>There are two kitchens at this facility, one in the rest home and one in the hospital. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal in both areas complies with current legislation and guidelines. The effectiveness of chemical use, cleaning, and food safety practices in each 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, and observation verifies compliance. The preventative maintenance programme for the management of pests is in operation.</p> <p>Evidence of residents' satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.</p> <p>There are sufficient staff on duty in all the dining rooms at meal times to</p>

		ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.
<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>An interview with both managers 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 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 includes the Needs Assessment and Service Coordination 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 both the rest home and hospital in the privacy of the resident's bedroom with the resident and/or family/whanau present if requested. However, the information documented is not always consistent with the resident's required needs.</p> <p>Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated. InterRAI assessments are reviewed six monthly, based on the schedule of when they are due. RNs are allocated 'paper days', and on those days they select residents on the schedule to review. Assessments are not consistently updated, within the six months, if residents' needs change.</p> <p>All resident records reviewed contained a current interRAI assessment in addition to other clinical assessments as indicated. In files reviewed, four episodes of acute events have no documentation requesting any ongoing assessment of the resident following that event. Wound care management includes comprehensive ongoing assessment, as does</p>

		<p>assessment of residents' activity requirements.</p> <p>A medical assessment is undertaken within 24 hours of admission and reviewed monthly or three monthly or as the resident's condition changes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Documentation, observation and interviews verify all residents have an individualised care plan. Assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support the resident requires from care staff, to meet their goals and desired outcomes.</p> <p>Care plans reviewed did not always describe the support required to achieve the residents' assessed needs. Inconsistency in assessment findings (refer 1.3.4.2) and an absence of a co-ordinated approach of service integration, evidences shortfalls in the care plan documentation. Any change in care required is documented in progress notes and verbally passed on to those concerned; however, this is not consistently updated in the care plan.</p> <p>Care plans are evaluated six monthly or more frequently as the resident's condition dictated. Residents and families interviewed confirmed their participation in the development of care plans and their ongoing evaluation and review.</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>FA</p>	<p>Observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes; however, this was not always supported by documentation (refer 1.3.5.2). The hospital and rest home manager are on call 24 hours a day to provide support and guidance. The RN in the hospital is accessible by phone to provide support for care delivery staff in the rest home. An interview with the GP confirmed satisfaction with the standard of care provided to residents.</p> <p>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, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme in the rest home is managed by a trained diversional therapist (DT) and the programme in the hospital is managed by two DTs. An interview with a DT from the rest home and a DT from the hospital advised that residents are assessed on admission to ascertain their previous and current interests, needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data.</p> <p>The residents' individualised activity plan is reviewed every six months or as residents' needs change.</p> <p>Documentation, observation and interviews verify activities reflect residents' goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. On the day of audit, children from the local kindergarten were in the rest home playing games with the residents.</p> <p>A residents' meeting is held monthly, in both areas. 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>As verified by documentation, observation and interview, 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 occur every six months or as residents' needs change.</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</p>

		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 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. 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>	FA	<p>Staff confirmed that they can access personal protective clothing and equipment at any time. This includes, gowns, gloves and eye protection. As observed, reusable gowns and disposable gloves were worn when required. The gowns were replaced with disposable gowns on the days of the audit. Waste storage and disposal meets legislative requirements.</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>	PA Low	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness for both the rest home and hospital buildings. The facility has a current warrant of fitness displayed.</p> <p>Maintenance is undertaken by both internal maintenance staff and external contractors. The electrical equipment was being test and tagged on the days of audit. Clinical equipment is tested and calibrated at least annually or as required as per the manufacturer's instructions. There is a monthly inspection of other equipment such as laundry, kitchen and hot</p>

		<p>water temperature monitoring. There are some areas for improvement in the environment.</p> <p>The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, and walking areas are not cluttered. If any areas of concern are identified in the environmental audits the issue is placed in the hazard register if it cannot be eliminated.</p> <p>There is access to external seating areas and gardens in both the rest home and hospital building. The double storey hospital building has access via stairs and lifts to the lower floor and external grounds. There is a veranda accessible from the upper level. Residents were sighted moving around safely both indoors and outdoors on the days of audit.</p> <p>Residents and family/whānau confirmed the environment is suitable to meet their needs.</p> <p>The prospective provider plans to maintain the ongoing maintenance schedule and does not intend to make any immediate changes to the layout of the service.</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>Residents' shower and toilet areas are centrally located in each wing. One room in the hospital building has an ensuite toilet and shower. The rest home rooms have ensuite toilets and hand basin, with centrally located bathing facilities. The bathroom doors have privacy locks to ensure residents can attend to their personal hygiene without interruption. There are bathrooms and showers that have disability access. There is a designated staff/visitor toilet.</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>One of the double rooms in the rest home is shared by a married couple who do not wish to have dividing curtains. Two other rooms in the rest home are suitable for double occupancy, and are single occupied at the time of audit. All other bedrooms in the rest home and hospital are single occupancy and 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</p>

		areas for residents to place personal belongings. Results from the relatives satisfaction survey and family/whānau members interviewed did not identify any concerns related to personal bed space or privacy.
<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	Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs on each of the levels in the hospital and rest home. The dining and lounge areas are separated. The areas are appropriately furnished to meet residents' needs. Residents and family/whānau voiced their satisfaction with the environment. As observed, activities are undertaken in the lounge and recreational areas. There are separate entrance and recreational areas for the day stay programme.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	There are secure storage areas for cleaning and laundry equipment in both the rest home and hospital buildings. The facility looked clean and was odour free, with the residents and families commenting on how well the service is cleaned and their laundry is looked after. The cleaning and laundry processes are monitored for effectiveness through satisfaction surveys.
<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>Staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. There is an approved evacuation scheme for the rest home and hospital buildings. The buildings are fitted with fire sprinklers, have indicator panels and have adequate fire equipment.</p> <p>The service has a civil defence kit, first aid kits and outbreak supplies. The service has adequate food and water for a minimum of three days. Waters tanks are accessible in both buildings. There are adequate torches and blankets in the case of an emergency. Trial evacuations of residents are conducted at least six monthly. Fire suppression systems are maintained and inspected monthly by the external contractor.</p> <p>The service has a call bell system in all resident areas. There is an audible alert through a staff pager system that alerts the room where the</p>

		call bell is activated. The residents and family/whanau report a timely response to the call bells.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	The facility is kept at a suitable temperature throughout the year by underfloor heating and wall mounted heaters where there is no underfloor heating. Resident areas have at least one opening window to provide adequate natural light. The residents and family/whanau reported satisfaction with the environment.
<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>A RN is the designated infection control coordinator in the hospital and the infection control coordinator role is currently undertaken by the rest home manager in the rest home until the role can be filled by another infection control coordinator. They have a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meetings, senior management meetings and continuous quality improvement meetings. The owners are informed of quality, risk and infection control issues. The review of the infection control programme was conducted within the last 12 months. The prospective purchaser does not intend to make changes to the programme, though will add infection control surveillance data in the monthly clinical quality indicator report to the Heritage Lifecare governance team.</p> <p>There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise relatives not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. Staff demonstrated good knowledge and application of infection prevention and control principles.</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</p>	FA	Infection control matters are discussed at the monthly management and continuous improvement meetings. If the infection control coordinator requires additional advice or support regarding infection prevention and control they can access this through the DHB, GP or diagnostic services.

the organisation.		
<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 policies and procedures have been developed by the organisation and reflect current accepted good practice. The service has access to good practice resources from a specialist infection prevention and control consultancy and benchmarking services. The policies are appropriate to the services offered by the facility.</p> <p>Staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions according to the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.</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>	FA	<p>The infection control coordinators/managers conduct most of the infection control education. There are some visiting specialists who provide infection control education and self-directed learning packages. The infection control coordinators/managers demonstrated current knowledge in infection prevention and control. They attended ongoing education on current good practice in infection prevention and control. As required, infection control education can be conducted informally with residents, such as reinforcement of infection control practices with washing hands, blowing noses, cough etiquette and personal hygiene when assisting with toileting.</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>	PA Low	<p>The service uses standardised definitions applicable to aged care that are provided by the external benchmarking service to identify infections. The type of surveillance undertaken is appropriate to the aged care service with data collected on urinary tract infections, influenza, skin infections and respiratory tract infections. There is monthly collection and collation of the types and numbers of infection in both the rest home and hospital services, though there was limited evaluation of this data (refer to 3.5.7). The data is also benchmarked on a quarterly basis with an external benchmarking service. The perspective provider intends to maintain the current infection control systems, with additional reporting of the statistics and analysis to their organisational wide governance/quality</p>

		<p>team.</p> <p>The outcomes are fed back to the staff at the next staff meeting. The infection surveillance records include the review and analysis of an outbreak that occurred in 2015. These record that the service had done 'extremely well' to minimise the spread of the outbreak and it was resolved quickly.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is no restraint used as confirmed in documentation reviewed, observations and staff interviews. The organisational policies indicated the service is committed to providing a restraint free environment. There are procedures in place to guide staff should enablers or restraint be required. Policy identified that the use of enablers will be voluntary and the least restrictive option to meet the needs of the resident to promote independence, comfort and safety. Staff demonstrated knowledge of restraints and enablers and what to do if they were required. Staff undertake annual education related to restraint minimisation and were able to verbalise de-escalation methods used to prevent any restraint use.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	The internal audit and accident and incident forms have a section for corrective actions. Where the internal audit or quality data indicated that there are shortfalls and corrective actions required, it is not always documented what actions have been implemented and if these actions have been effective. The management and staff were able to verbalise the actions that have been developed and implemented.	It was not always evidenced on incident forms, internal audits and infection control data that corrective actions are identified and implemented.	<p>Ensure corrective action plans addressing areas requiring improvement are consistently implemented.</p> <p>180 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to</p>	PA Moderate	Incident and accident reporting processes in the hospital section evidenced that incidents are documented and any corrective actions to be taken are shown on the forms,	Four of the five accident and incident forms in the rest home do not record the risk management strategies (such as neurological observations	Provide evidence that the risk management strategies (such as neurological observations after a fall) are documented.

improve service delivery, and to identify and manage risk.		recorded in the progress notes, and as required, short term care plans were implemented. The incident forms reviewed in the rest home of residents who had unwitnessed falls or falls with head injuries did not record any follow up risk assessment (such as neurological observations).	after a fall).	60 days
Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.	PA Moderate	The files in the rest home are kept secure and only accessible to authorised people; however, the files in both levels of the hospital are in offices that are freely accessible to anyone. The cabinets containing the files is not secure and both offices where the hospital files are located are often unattended and the door to the office unlocked. Staff are often busy and would not be aware of unauthorised people entering or leaving the offices. The combination of these factors contributes to a potential risk of a privacy breach.	Information in the hospital is not always maintained in a secure manner that is not publicly accessible.	Provide evidence that residents' files in the hospital are kept secure. 90 days
Criterion 1.3.12.1 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.	PA Low	The medicine fridge in the rest home is in the nurses office and freely accessible to anyone entering or passing through the office.	Storage of refrigerated medicines in the rest home is not safe.	Provide evidence refrigerated medicines in the rest home are securely stored 60 days

<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	<p>PA Low</p>	<p>Residents' interRAI assessment and long term care plans were undertaken by a RN, however the admission and initial assessment of residents in the rest home was undertaken by an EN or senior caregiver if the RN is not on duty as evidenced in all rest home files reviewed. The general manager and the rest home manager (interviewed) were unaware of the contractual requirement for admission assessments to be undertaken by an RN.</p>	<p>Admission and initial assessment of residents in the rest home is not undertaken by a RN.</p>	<p>Provide evidence that each stage of service provision is provided by a RN.</p> <p>60 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	<p>PA Low</p>	<p>Residents in the rest home are routinely reviewed by the GP three monthly as evidenced in all files reviewed.</p> <p>There was no sighted documentation to evidence the GP has verified the resident is stable and suitable for three monthly reviews. During interview, the GP was unaware that all residents had to be verified by the GP as stable and suitable for three monthly rather than monthly reviews.</p>	<p>Each stage of service provision meets timeframes, with the exception of GP reviews in the rest home.</p>	<p>Evidence is provided that GPs review residents within the required timeframes to meet their needs.</p> <p>90 days</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>	<p>PA Low</p>	<p>The initial care plan of two residents (one hospital and one rest home) recently admitted, had no documentation verifying comprehensive assessment of skin integrity, nutrition, behaviour, or pressure injury risk.</p> <p>Three residents (one rest home and two hospital) who had fallen had an initial assessment completed following</p>	<p>Residents have their needs identified through a variety of information sources including the assessment process; however, assessment documentation is not always consistent with the residents' required needs.</p>	<p>Provide evidence residents are comprehensively assessed on admission and reassessed when there is a change in condition.</p> <p>90 days</p>

		<p>the fall, however, no documentation verifying ongoing monitoring is recorded. There was no evidence sighted on the day of audit to verify monitoring had occurred.</p> <p>InterRAI assessments are not updated within the six month time frame if residents' needs change.</p> <p>All files reviewed had no evidence of cultural needs being assessed, or a consideration to cultural needs requiring attention in care planning.</p>		
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>Service delivery plans describe the required support to achieve the desired outcomes; however this is not always consistent.</p> <p>Two residents recently admitted (one hospital and one rest home), had documentation to verify their needs in relation to activities of daily living, however no management strategies were documented to manage skin integrity needs, cultural needs, or pressure injury risk (refer 1.3.3.3 and tracer 2).</p> <p>A diabetic resident had no plan of care to manage the resident's diabetic needs; however the kitchen was providing the resident with a diabetic diet and the residents blood sugar levels were being monitored, as per sighted evidence.</p> <p>Three residents who had fallen had an initial assessment and subsequent</p>	<p>Service delivery plans are inconsistent and do not accurately reflect the support the resident requires to meet their needs.</p>	<p>Provide evidence that service delivery plans describe the required support to achieve desired outcomes.</p> <p>90 days</p>

		<p>documentation completed. Incident reports were completed and families were informed of the incident however no management strategies were documented to identify the required monitoring following the fall. No evidence was sighted monitoring occurred.</p> <p>A resident recently re-admitted, following a complex referral for specialist services, had an increased level of needs in relation to some aspects of care required. Not all of these had been updated in the care plan, and interviews with care staff evidenced some staff not being aware of all aspects of the care the resident required. Evidence verified the GP had been informed of any changes, as requested.</p> <p>A resident exhibiting episodes of challenging behaviour had documentation in the progress notes recording the episodes of challenging behaviour, however there was no management plan that captured suggested management strategies to manage the behaviour.</p> <p>A resident identified as a pressure injury risk had management strategies in place to manage the risk, however these were not reviewed after they were found to be ineffective, and a change in management was required.</p>		
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<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>The overall maintenance of the service is conducted to a high standard, with resident and family/whānau commenting on the ongoing upkeep of the environment and grounds. There are some areas of wear and tear in the rest home kitchen and laundry, which is the older of the buildings. The storage methods of the chemicals in both kitchens and some linen in the hospital does not reflect current accepted good practice.</p>	<p>There are surfaces in the rest home kitchen that are chipped. The surfaces in the rest home laundry are deteriorating. There is timber exposed on the hand basin, rusting surfaces in the sink used for soaking and rusting areas on the drier.</p> <p>There were chemicals stored un-secured in both kitchens.</p> <p>There is linen stored in the upper level of the hospital on open shelves, which does not reflect best infection prevention and control practices by exposure to potential contamination of the clean products.</p>	<p>Provide evidence that all chemicals are securely stored.</p> <p>Provide evidence that the surfaces in the rest home laundry and rest home kitchen are intact and that linen storage in the hospital are in line with infection prevention and control practices and guidelines.</p> <p>90 days</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>PA Low</p>	<p>The infection data reviewed for 2016 records the collation and graphing of the infection data. The number and types of infections are included in the manager's monthly report, though there was little analysis and evaluation of the data and little documented evidence of how the outcomes have been acted upon. There is evidence of how actions have been implemented for individual residents, through short term care planning, though no overall evaluation of the surveillance data. The service receives benchmarking reports from the external service, but no specific</p>	<p>The infection control data contained collation of the number and types of infections, though no clear documentation of the how the outcomes are acted upon and evaluated.</p>	<p>Provide evidence that the infection surveillance data is consistently evaluated and outcomes are acted on.</p> <p>90 days</p>

		analysis for the service.		
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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.

No data to display

End of the report.