

Ropata Lodge Limited - Ropata Lodge

Introduction

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

The audit has been conducted by 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:	Ropata Lodge Limited
Premises audited:	Ropata Lodge
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 August 2016 End date: 18 August 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:	9

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ropata Lodge is newly certified to provide rest home care for up to 34 residents. The service is operated by Ropata Lodge Ltd and managed by a facility manager who also takes the role of the clinical nurse manager. The service was first certified following a provisional audit in November 2015. The number of residents has been increasing slowly since that time, up to its current level of only nine residents.

This certification audit is the services first audit since the facility started as a provider of rest home level care. It was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, management, staff, a human resources consultant and a general practitioner.

This audit has resulted in areas requiring improvements relating to organisational planning, quality systems, residents' care plans, medication management and infection control.

Residents interviewed spoke positively about the care being provided.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Standards applicable to this service fully attained.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

There were no residents who identify as Māori on the days of audit, however processes are in place to ensure any residents who do identify as Maori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has links with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	--	--

The owner of the facility is responsible for the service provided at this facility. A business is documented and includes the scope, direction, business goals and mission statement of the organisation. Systems are in place for monitoring the services provided, including regular weekly reporting by the facility manager at the weekly meetings held with the owner.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse (RN). A quality improvement plan and system is in place which includes internal audit activity, monitoring of complaints and incidents, health and safety, infection control and resident and family satisfaction. While the collection, collation and analysis of quality improvement data is occurring and is reported to the owner and other staff, this is not being presented in a consistent and systematic way. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Formal and informal feedback from residents and families is used to improve services. There is not yet a formalised risk register to identify actual and potential risks with relevant mitigation strategies. The hazard register is kept up to date.

A suite of policies and procedures cover the necessary areas, are current and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme ensures staff are competent to undertake their role. A robust approach is in development to identify, plan facilitate and record ongoing training that supports safe service delivery. Regular individual performance reviews are being completed.

Staffing levels and skill mix meet contractual requirements and the needs of the residents. There is a roster for an RN on call out of hours.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission, however this is not always within the required timeframes. Registered nurses are on call 24 hours each day in the facility and are supported by care and allied health staff. A designated general practitioner (GP) is available to attend to residents who are unable to access the services of their own GP. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information, though documentation does not always capture the required support the resident requires. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents interviewed reported being well informed and involved in care planning and evaluation, and that the care provided

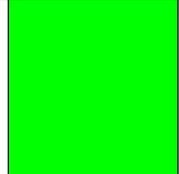
is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by an activity co-ordinator, provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are managed according to policies and procedures; however, some areas have been identified as requiring improvement. Medications are administered by senior care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

Safe and appropriate environment

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

The facility was originally built as 34 independent living apartments. All the individual rooms/units are spacious and include ensuites and kitchenettes with ample space to enable assistance as required.

All building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

The dining room and the two communal lounge areas are of sufficient size and maintained at a comfortable temperature. An internal courtyard with seating is available and all rooms have individual balconies or courtyards.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite, with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to an emergency power source is available. Residents report a timely staff response to call bells. A contracted security company monitors the facility each night.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	---	--

The organisation has developed policies and procedures that support the minimisation of restraint. There are currently no residents who require restraint or who use any enablers. Restraint would only be used as a last resort when all other options have been explored. Any enabler use would be voluntary for the safety of residents in response to individual requests. Staff receive training at orientation including all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated a sound knowledge and understanding of restraint and enabler policies and procedures.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
--	--	---

The infection prevention and control programme, led by the facility manager, aims to prevent and manage infections. Specialist infection prevention and control advice is able to be accessed from the district health board.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with planned regular education.

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	38	0	2	5	0	0
Criteria	0	83	0	4	6	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>Ropata Lodge has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in planned ongoing training.</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>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, and collection of information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility and additional brochures were available at reception. Residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff are aware of how to access the Advocacy Service. The service has a residents' advocate who attends the residents' meetings when able, and is available to the residents for guidance if required.</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 and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Residents verified family members felt welcome when they visited and comfortable in their dealings with staff.</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 complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available in a number of areas in the facility.</p> <p>The complaints register reviewed showed that three complaints have been received so far this year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans reviewed show any required follow up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with staff, and ongoing discussion with the facility manager (FM). The Code is displayed in communal areas together with information on advocacy services, how to make a complaint and feedback forms.</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>	<p>FA</p>	<p>Residents confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit (for example, when attending to personal cares, ensuring resident information is held securely and privately, and when exchanging verbal information). All residents have a private room with their own ensuite.</p> <p>Residents are encouraged to maintain their independence by being assisted to participate in community activities and participation in clubs and outings of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff and is to be provided annually, as confirmed by review of the planned education programme.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There were no residents who identify as Maori in the service at the time of audit. However, processes are in place to support residents who identify as Māori to integrate their cultural values and beliefs.</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>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed (for example, food and spiritual requirements). The resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p>	<p>FA</p>	<p>Residents interviewed stated that residents were free from any type of discrimination, harassment or</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education will also be provided on an annual basis, which was confirmed in interview with the FM and the sighted education schedule. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, community dieticians, services for older people, psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents stated they were kept well informed about any changes. The family communication record and resident interviews evidences family members were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are able to be accessed when required. Staff knew how to do so, although reported this was rarely required due to all present residents being able to speak English.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Low</p>	<p>The combined business / strategic plan (2015-2020) includes the philosophy, vision / mission statement along with the business goals, direction, and market analysis for the organisation. The facility manager meets weekly with the owner and the financial manager, where all aspects of service provision, including quality data and business management, are discussed and minuted. A sample of minutes reviewed showed the quality of service performance is regularly discussed and reported on, as is relevant financial performance, emerging risks and issues. There is no service specific planning included in the planning process.</p>

		<p>The service is managed by a facility manager who is a registered nurse with significant experience in the aged care sector and who has been in the role for two years. She has responsibilities and accountabilities defined in a job description and individual employment agreement. The Facility Manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through the Nursing Council of New Zealand. The facility manager is supported by a small team including a registered nurse, finance manager and administration manager who meet weekly. The owner, who has owned a number of facilities previously, is available to provide additional support as required.</p> <p>The service holds a contract with DHB for the provision of respite and rest home level care. Nine residents receive services under the contract at the time of audit.</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>	<p>FA</p>	<p>When the facility manager is absent, the registered nurse carries out all the required duties under delegated authority. The owner is also available on call as necessary. During these absences the clinical management is also overseen by the registered nurse, who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>The organisation has a quality improvement and risk management plan that reflects the principles of continuous improvement and is understood by staff. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and falls, and health and safety.</p> <p>Meeting minutes reviewed confirmed discussion occurs on quality matters. Regular review and analysis of the current quality indicators does occur and related information is reported and discussed at the management team meetings and staff meetings. This process is currently not formalised. Minutes reviewed include discussion on pressure injuries, falls, complaints, incidents/events, infections, audit results and activities. Staff reported their involvement in quality and risk activities through internal audit activities and regular monthly staff meetings where issues are discussed. Relevant corrective actions are developed and implemented as necessary. Resident and family surveys are completed annually. The last survey showed a general satisfaction with services provided.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements and are current. The document control system ensures a systematic and regular review process, referencing</p>

		<p>of relevant sources, approval, distribution and removal of obsolete documents. As this is a small service, staff are able to be updated on new policies or changes to policies through the regular staff meetings.</p> <p>The health and safety representative is aware of the Health and Safety at Work Act (2015) requirements, has attended relevant training and is implementing requirements.</p> <p>There is currently no formal risk register developed.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is collated, analysed and reported to the weekly management meetings and minutes reviewed show discussion in relation to trends, action plans and improvements made.</p> <p>Policy and procedures described essential notification reporting requirements for pressure injuries, health and safety, human resources, infection control, the coroner and the DHB. The facility manager advised there have been no notifications of significant events made to the Ministry of Health since the provisional audit.</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>	FA	<p>Policies and procedures, in line with good employment practice and relevant legislation, and guide human resources management processes. Additional support is provided through an HR consultant who is contracted to provide expertise and guide all processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed show documentation of completed orientation and regular performance reviews.</p> <p>Continuing education is being planned on an annual basis. Mandatory training requirements are defined and scheduled to occur over the course of the year. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Education records reviewed demonstrated completion of the some of the required training since the service was certified in November last year. Scheduled training</p>

		<p>over the next 12 months will complete that process. Staff reported that their annual performance appraisal process provides an opportunity to discuss individual training needs, supervision requirements and review competencies. Appraisals were current for all staff.</p> <p>InterRAI training had been delayed due to the small number of facility residents under the DHB contract, as they were not considered a priority to access training for the limited number of spaces available. This training has now been completed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet any changing needs of residents, however with the service currently being so small the staffing levels required are consistent. The minimum number of staff is provided during the night shift and consists of two health care assistants. An afterhours RN on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of two fortnightly roster cycles sampled during this audit confirmed adequate staff cover has been provided. The organisation contracts to a bureau if it is unable to find cover from its casual pool for short notice roster gaps. At least one staff member on duty has a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager. They are also provided with written information about the service and the admission process. The</p>

<p>manner, when their need for services has been identified.</p>		<p>organisation seeks updated information from the NASC or GP for residents accessing respite care.</p> <p>Residents interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed assessments and signed admission agreements in accordance with 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 as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records is provided 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 medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</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. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates, with the exception of eye drops, where no record is sighted of when these were opened. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly stock checks and accurate entries, however no record of six monthly checks is sighted. This is verified by the FM</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There are no residents who self-administer medications at the time of audit. Appropriate processes</p>

		<p>are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the FM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are not used.</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>	FA	<p>The food service is provided on site by a cook and kitchen hand, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an 'A grade' kitchen certificate approved by the Lower Hutt City Council. Food temperatures, including for high risk items, are monitored appropriately and recorded. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the FM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity and nutritional screening as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents, with the exception of one (refer 1.3.3.3) have current interRAI assessments completed by one of two trained interRAI assessors on site.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Plans reviewed did not always reflect fully the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents reported participation in the development and ongoing evaluation of care plans.</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>Observations, documentation and interviews verified the provision of care provided to residents was consistent with their needs, goals and their desired care (refer 1.3.5.2) The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</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>	FA	<p>The activities programme is provided by an activity co-ordinator, who is enrolled to do the national Certificate in Diversional Therapy.</p> <p>A social assessment and history of all residents has been undertaken to ascertain residents' needs, interests, abilities and social requirements, to help formulate an activities programme that is meaningful to the residents. The resident's activity needs will be evaluated as part of the formal six monthly care plan review. Present residents have not been there for long.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities programme is discussed at the residents' meetings and minutes indicate residents' input is sought</p>

		and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme valuable and caters to their needs.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Resident files reviewed, were of residents who had been in the service for less than six months. Policy identifies formal care plan evaluations, will occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change and this was verified during interview with the FM. Day to day evaluations are documented by the RN. Where progress is different from expected, the service responds by the RN initiating changes to the plan of care. Short term care plans were consistently reviewed and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents interviews and documentation verified resident involvement and documentation provided examples of family/whanau involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. Referrals are followed up on a regular basis by the FM or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste,	FA	Documented processes for the management of waste and hazardous substances were in place. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal. The doors to the areas, both inside and outside, storing chemicals were secured and containers labelled. Appropriate signage is displayed where necessary. An external company is contracted to

<p>infectious or hazardous substances, generated during service delivery.</p>		<p>supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Any related incidents are reported in a timely manner.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this, including both the care and cleaning staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness which expires on 25 March 2017, is publically displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with personnel and observation of the environment.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</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>All rooms have ensuites which are adapted to ensure they are suitable for residents to use either independently or under supervision. In addition there are accessible toilets throughout the facility. Appropriately secured handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed</p>	<p>FA</p>	<p>The rooms, which were originally small independent living apartments, are very spacious with adequate space to allow residents and staff to move around within their room safely. All rooms provide single accommodation complete with small kitchenettes. Rooms are personalised with furnishings, photos and other personal items displayed.</p>

<p>areas appropriate to the consumer group and setting.</p>		<p>There is room inside each apartment to store any mobility aids including walking frames and wheel chairs. Staff and residents reported the adequacy of their personal spaces.</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>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and smaller communal lounge areas enable easy access for residents and staff. Residents are able to access smaller alcove areas or their rooms for privacy, if required. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely</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>	<p>FA</p>	<p>All laundry is undertaken on site in a small dedicated laundry. Plans to relocate this to a larger area are in place. Resident's personal items are laundered on site or by family members if requested. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently washed by care staff, usually by the night staff, who demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen.</p> <p>There is a designated cleaner who has received appropriate training. This was confirmed in her training records. Chemicals were stored in a small lockable room and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 4 October 2015. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 14 July 2016. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, torches and a gas BBQ were sighted and meet the requirements for the current residents. A new water storage tank is located outside and there is an arrangement with the powers supplier to prioritise the supply of a generator to the facility. Emergency lighting which will run for up to 48 hours, is regularly tested.</p>

		<p>Call bells alert staff to residents requiring assistance. Call system audits are currently completed informally on a regular basis. Once numbers increase the manager confirms this will be included into the internal audit programme. Residents reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a regular time in the evening and a security company checks the premises at night.</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>	FA	<p>All residents' rooms and communal areas have opening external windows. Most have doors that open onto the courtyard, small patios or balcony areas. Gas heating provided is provided with radiators in all rooms with additional heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents confirmed the facilities are maintained at a comfortable temperature.</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>	PA Moderate	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the FM. The infection control programme has not been reviewed annually, however the manual was reviewed July 2015</p> <p>The FM is the designated IPC coordinator, however there is no defined job description in place for this role, and no up to date training for this role has occurred. Infection control matters, are reported monthly at the staff meeting and to the facility owner, however there is no formal process operating to record and analyse infections.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</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</p>	FA	<p>Observation, interviews and documentation verifies there are adequate resources to implement the programme, however the infection prevention and control (IPC) coordinator has no formal training in IPC, other than skills and knowledge she has gained via on line learning in IPC (refer 3.1.1). She has been in this role for one year. Well-established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional</p>

<p>programme and meet the needs of the organisation.</p>		<p>support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed IPC audits occur regularly, and results are fed back to staff at staff meetings, and there are sufficient resources available to support the programme and any outbreak of an infection.</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>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in July 2015 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme. Interviews and observation and documentation verified staff are familiar with and received education in infection prevention and control at orientation, and also in training sessions at staff meetings. Annual IPC training is included on the planned training schedule for November 2016. Education will be provided by the infection control coordinator (refer 3.1.1)</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods</p>	<p>PA Moderate</p>	<p>Interviews, observation and documentation verifies, when an infection is identified, a record of this is documented on the resident's short term care plan, with an appropriate management plan, as advised by the resident's GP. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Staff verify preventative and ongoing management strategies to minimise the spread of infections. The IC coordinator has not implemented a formalised surveillance</p>

<p>that have been specified in the infection control programme.</p>		<p>programme. Monthly surveillance data is not collected, collated and analysed to identify any trends, possible causative factors and required actions. Documentation and interviews verify rates are low.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The facility is currently a restraint free environment and there are no enablers in use. Should any resident request an enabler, the procedures in place will then be implemented. The facility manager demonstrated a sound understanding of the organisation's policies, procedures and the role and responsibilities required in the facility should any future need be identified.</p> <p>Interviews with staff confirmed their understanding of both restraint and enabler 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 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	The business plan is focused on the industry, the company profile and facility along with a sales and marketing analysis. There is no service specific planning included in the current planning process to assist the facility manager in developing the service delivery aspects of the organisation.	There is a lack of specific annual goals, objectives or any service related planning included in the business planning cycle that can provide direction for the management of the delivery of services.	<p>Further develop the business planning process to include service specific goals and objectives to provide clear direction to support and provide guidance to the service management team.</p> <p>365 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and,</p>	PA Low	Quality data is being collected with some evaluation and trend analysis completed but this is not consistent across all the indicators. There is no formal process to communicate results to service providers,	While there is a quality improvement and risk management plan developed, this is not	Develop and implement a system that will collect all data into a format that enables

where appropriate, consumers.		and where appropriate, consumers. There is some evidence this occurs in some staff and resident meetings but the process is not adequately planned and implemented. The manager confirmed quality discussions are a regular agenda item in these meetings but there is no systematic reporting process.	being formally implemented into a process that clearly links all the data collected, with relevant analysis, into a consistent way to enable robust reporting and evaluation of all quality improvement data.	reporting on trends, corrective action reporting and evaluation across all quality indicators which will also support reporting and measuring achievement against the quality and risk plan (see also 1.2.3.7). 180 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	There is no process evident to measure actual achievement against the quality improvement and risk management plan. While the information gathered relates back to the plan, the manager reports there is no formalised process to document any measurement of the achievement against the specific areas that are being targeted in the plan. Meeting minutes confirmed relevant discussion and activity does occur for all corrective actions which are signed off when completed, but these are not formally linked back to the specific goals in the quality plan.	A process that links all the quality data collected to enable regular measurement of progress against the quality plan has not yet been developed to reflect the actual positive activity that is occurring.	Provide evidence of a formalised process that enables measurement of actual achievement and progress against all the elements included in the plan. Refer also 1.2.3.6. 365 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those	PA Moderate	The facility has no risk register with mitigating strategies to manage risks associated with providing services. The owner reported he provides significant support to the facility manager and works closely to ensure any business and service	There is no formalised risk register developed to identify actual and potential risks and then, where	Identify and document all potential and actual service provision risks, with relevant analysis, monitoring

<p>commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>concerns are addressed, however there is no documentation that identifies any of the risks that are associated with the service provision and what processes are in place to address any of these. This was also confirmed in interview with the facility manager and following a review of all documentation.</p>	<p>appropriate, communicate these to relevant stakeholders.</p>	<p>and review, and then develop and implement a process that addresses/treats those risks. Where appropriate, communicate these to relevant stakeholders.</p> <p>90 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>	<p>PA Moderate</p>	<p>Documentation, observation and interviews verify all medications sighted are within their current use by dates, with the exception of residents prescribed eye drops. There is no system in place to ensure eye drops are used within the required use by dates when opened.</p> <p>The controlled drug register verifies controlled drugs are checked by two staff every week, however there is no documented evidence of a six monthly check. This is verified by interview and observation.</p>	<p>Eye drops being used, had no evidence to verify their use by dates, since opening, had not expired. There is no documented evidence of controlled drugs being checked six monthly.</p>	<p>Ensure eye drops are used within their use by dates and the controlled drug register has the required six monthly checks.</p> <p>90 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>Documentation, interviews and observation verifies all residents are assessed on admission and an initial care plan developed within twenty-four hours. Over the following three weeks' comprehensive clinical assessments are undertaken, however three of the five files reviewed had no long term care plan developed within three weeks. Of those five files reviewed</p>	<p>Long term care plans and interRAI assessments are not always completed within three weeks of admission.</p>	<p>Provide evidence long term care plans and interRAI assessments are undertaken within three weeks of admission</p>

		one had no evidence to verify an interRAI assessment had been undertaken.		180 days
<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>	PA Moderate	Care plans evidence service integration, however three of five files reviewed had no documented management plan in place to manage the identified risk around preventing pressure injuries, falls and specific management of a medical condition. Interviews, documentation and observation verified this was a documentation and not a practice issue. Interventions provided were in line with residents desired outcomes.	Interview with the facility manager and sighted documentation verified long term care plans did not always describe the required support identified in the assessment process.	<p>Provide evidence long term care plans describe the required support identified in the assessment process.</p> <p>90 days</p>
<p>Criterion 3.1.1</p> <p>The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.</p>	PA Moderate	Observations, documentation and interviews verifies the service provides a managed environment that minimises the risk of infection to residents, staff and visitors. The FM is responsible for IPC and ensures the environment is managed to minimise the risk of infection to residents, staff and visitors, however the IPC coordinator has no formal training in IPC and no job description to clearly define the role and the responsibility.	The responsibility for infection control is not clearly defined with no job description, no formal training in ICP provided and no clear lines of accountability for infection control matters as evidenced by documentation and interviews with the IPC coordinator.	<p>Provide evidence the responsibility for IPC is clearly defined, and formal IPC training provided to the ICP co-ordinator</p> <p>90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that</p>	PA Moderate	Documentation, observation and interviews verify the organisation has an ICP, however it is not site specific. Generalised ICP practices are occurring in line with the	Documentation, observation and interview verifies an infection control	Provide evidence that the infection control programme reflects the ICP

<p>is reviewed at least annually.</p>		<p>programme, ie ICP training at orientation and ongoing, the adherence to standard precautions, audits of IC practices and the availability of equipment and supplies to ensure IC practices are maintained, however it makes reference to some aspects of a programme that are not occurring at Ropata. The date on the sighted programme is 2013/2014.</p>	<p>programme is operating however it has not been reviewed annually and the programme sighted has not been reviewed to determine its relevance to the facility.</p>	<p>operating at Ropata and is reviewed annually.</p> <p>90 days</p>
<p>Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>	<p>PA Moderate</p>	<p>All residents with infections have a management plan in place to manage the infection, however interviews, observations and documentation verifies there is no formal IC surveillance programme operating nor is there any analysis to identify possible conclusions and recommendations to assist in IPC reduction and prevention.</p>	<p>There is no formal IC surveillance programme operating as evidenced by documentation, interviews and observation.</p>	<p>Evidence is provided that an IPC surveillance programme is operating, with the results of findings and analysis acted on.</p> <p>90 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.

No data to display

End of the report.