

Thornton Park Retirement Lodge Limited - Thornton Park Retirement 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 HealthShare 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:	Thornton Park Retirement Lodge Limited
Premises audited:	Thornton Park Retirement Lodge
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 November 2016 End date: 22 November 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:	38



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

Thornton Park can provide care for up to 42 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and one medical officer.

The clinical nurse manager is responsible for the overall management of the facility and is supported by the support assistant. Service delivery is monitored.

Improvements are required to the following: to advance directives; integration of resident records; the quality programme including documentation of adverse events; staff training; documentation of assessments, interventions and medication management; food services; and calibration of medical equipment.

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.

Some standards applicable to this service partially attained and of low risk.

Residents receive services in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The systems protect their privacy and promote their independence. There is a documented Maori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Management and staff communicate in an open manner and residents and relatives are kept up-to-date when changes occur. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices.

The rights of residents or their legal representatives to make a consumer complaint is understood, respected and upheld. An up-to-date complaints register is maintained.

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.

There is an annual business plan in place which defines the scope, direction and objectives of the service and the monitoring and reporting processes. The service is managed by the facility manager who is a registered nurse with a current practising certificate.

The framework around a quality and risk management system is documented. There are a range of policies and forms in place to guide practice. Quality outcomes data is collected with a process in place to record adverse events.

The human resource management system is documented and consistent with accepted practice. There is an orientation programme in place.

There is a documented rationale for determining staff levels and staff mix in order to provide safe service delivery in the rest home and hospital. An appropriate number of skilled and experienced staff are allocated each shift with a full complement of registered nurses now in place.

Resident information is stored securely.

Continuum of service delivery

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Each stage of service provision is coordinated to promote continuity of service delivery. Residents and family interviewed confirm access to typical range of life experiences and choices.

A sampling of residents' clinical files validated service delivery to residents. Residents and family expressed satisfaction with services provided.

Planned activities are appropriate to the group setting. Individual activities are provided either within group settings or on a one-on-one basis.

The medicine management system is in place. Staff responsible for medicine management have current medication competencies. There were no residents self-administering medicines at the facility on audit days.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. There is a central kitchen and on site staff that provide the food service.

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.		Some standards applicable to this service partially attained and of low risk.
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All building and plant comply with legislation with a current building warrant of fitness and New Zealand Fire Service evacuation scheme in place. Equipment is tested annually with electrical checks occurring. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Residents have access to outdoor areas that are safe.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

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.
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The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There were three residents using restraint and six residents requesting enablers on audit days.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The policies and procedures guide staff in areas of infection control practice. New employees are provided with training in infection control practices and there is on-going infection control education available. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided.

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	37	0	6	7	0	0
Criteria	0	85	0	8	8	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>Policies and procedures are in place to ensure consumer rights are respected by staff. Staff receive education during orientation and ongoing training on consumer rights is included in the staff annual training schedule.</p> <p>Staff interviewed are all able to articulate knowledge of the Health and Disability Commissioner's Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. Staff interviewed confirm they receive ongoing education on the Code.</p> <p>Visual observations during the audit and the review of clinical records and other documentation indicate that staff are respectful of residents and incorporate the principals of the Code into their practice. The service provides information on the Code to families and residents on admission.</p> <p>Residents and family interviewed state that they receive services as per the Code.</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</p>	PA Low	<p>There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. Staff use verbal consents as part of daily service delivery. Staff interviewed demonstrate an understanding of informed consent processes. Residents and relatives confirmed that consent issues are discussed with the relatives and residents on admission and appropriate forms are shown to them at this time and thereafter as relevant. All</p>

<p>informed choices and give informed consent.</p>		<p>residents' files reviewed included written consent.</p> <p>All residents have the choice to make an advance directive however evidence of documentation of their decision in records reviewed when competent was not sighted.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There are policies in place regarding advocacy and/or support services. Advocates can also be accessed through the Nationwide Health and Disability Advocacy Service if required. The Nationwide Health and Disability Advocacy Service brochure is offered to the resident and their family/whānau on admission. These brochures are also displayed in the entrance foyer of the facility. Education on advocacy is provided to staff during orientation and in the ongoing in-service programme.</p> <p>Residents and relatives interviewed confirmed they are aware that advocacy services are available should they be needed.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents have open access to visitors of their choice. Resident safety and well-being is not compromised by visitors to the service. Access to community support/interest groups is facilitated for residents as appropriate. The activities staff are available to take residents on community visits and staff are available to take people to appointments if family are not able to provide transport.</p> <p>Residents interviewed confirmed they can have access to visitors of their choice at any time and are supported to access services within the community. Family/whānau were seen visiting residents on the days of audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints management policy and procedure is documented and follows Right 10 of the Code. The complaints policy and procedure is explained by the staff as part of the admission process. There are complaint forms available at the main entrance to the building. Residents' complaints are managed by the clinical nurse manager or support assistant. An up-to-date resident complaints register is maintained.</p> <p>A complaint was tracked with this resolved in a timely manner as per policy. Staff, residents and families interviewed have a good understanding of the complaints process.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Information on the Code and the Nationwide Health and Disability Advocacy Service are displayed in the facility and included in the admission information pack. The Code and other rights and information in the information pack are discussed with residents and relatives on admission.</p> <p>Residents and relatives interviewed confirmed that the Code, the advocacy service and residents' rights are explained on admission.</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>There are a range of policies and procedures in place to ensure residents are treated with respect Staff endeavour to maximise residents' independence. There is respect for residents' spiritual, cultural and other personal needs. Residents are referred to by their preferred name.</p> <p>The service has a philosophy that promotes dignity and respect and quality of life. Residents' support needs are assessed using a holistic approach. The assessment process includes gaining details regarding people's beliefs and values. Residents and family confirmed that they are included in the care planning process and are addressed by their preferred name. Caregivers state that they support the residents' independence by encouraging them to be as active as possible and there are continued links for residents with the community.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner. This includes strategies to manage any behaviours of concern. Staff are able to describe support for residents around sexuality and intimacy.</p> <p>The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility that can be used for private meetings. Caregivers reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and relatives interviewed stated that staff have regard for the dignity, privacy, and independence of residents.</p> <p>There is a policy around abuse and neglect. Staff can describe the process for managing any issues related to abuse and neglect. Staff, residents and family and the general practitioners interviewed state that there is no evidence of abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p>	<p>FA</p>	<p>There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff in care</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>provision for Maori residents. The documentation is referenced to the Treaty of Waitangi and includes guidelines on partnership, protection and participation.</p> <p>Staff interviewed confirm an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training.</p> <p>Staff in the service identify predominantly as Māori and they are able to support residents who wish to speak te reo. On the days of audit there were residents who identify as Māori. The cultural needs for both Māori residents were reflected in their assessment and care planning documents.</p> <p>Access to Māori support and advocacy services are available if required. Systems are in place to allow for review processes including input from family/whanau as appropriate, for residents who identify as Māori. Links have been made with the Māori community including local marae and Māori health providers. The support assistant is Māori and works with the community to support people wishing to be referred to the service. Both the clinical nurse manager and the support assistant have strong links into the community and to iwi.</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>There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan.</p> <p>Staff interviewed confirm their understanding of cultural safety in relation to care.</p> <p>Residents and family members interviewed confirmed that values and beliefs are respected by staff.</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>There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives interviewed reported that staff maintain appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an</p>	<p>FA</p>	<p>Residents state that they receive a high quality service and all state that they enjoy living at Thornton Park. Family also confirmed residents' acknowledgement of the quality of service.</p>

<p>appropriate standard.</p>		<p>Residents and family describe a culture of caring and support that extends over and above the expected norm.</p> <p>There are policies and procedures in place to guide service delivery (refer 1.2.3). Management and staff have access to, and demonstrate knowledge of approved service standards. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice.</p> <p>The education programme includes training requirements for staff (refer 1.2.7). Staff interviewed confirmed that the facility provides a supportive environment.</p> <p>The clinical nurse manager and support administrator maintain strong links with the community and both have extensive knowledge of family/whanau links. This includes knowledge and understanding of resident's needs relative to their community.</p> <p>The general practitioner interviewed praised the service for the quality of care provided.</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>The service provider has policies covering communication, access to interpreters and the clinical nurse manager and support administrator maintain an open-door policy. Information is provided in a manner that the resident can understand. Relatives and residents can discuss issues at any time with staff. Resident meetings are conducted. The incident and accident forms include an area to document if the relatives have been contacted with all reviewed indicating that family are contacted when an incident has occurred. Open disclosure is practised and documented when family are contacted.</p> <p>Residents and relatives interviewed confirmed that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirmed that they are advised if there is a change in their family member's health status. The general practitioners interviewed reported satisfaction with communication by staff.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Low</p>	<p>The organisation is privately owned. The service provides for residents requiring rest home or hospital level of care with 19 residents requiring rest home level of care and 18 requiring hospital level care on the days of audit. One resident was supported through respite care.</p> <p>The mission statement and values are documented and known to staff, residents and family members. Some plans are documented including goals of the organisation with evidence of some review.</p> <p>Organisational performance is monitored by the clinical nurse manager and support assistant</p>

		<p>with support from the owner as required.</p> <p>The clinical nurse manager is responsible for ensuring services are planned, coordinated and appropriate to meet the needs of the residents. The clinical nurse manager is a registered nurse with a current practising certificate and has been in the role for over three years. Prior to this they were employed by the facility as a caregiver then registered nurse.</p> <p>Both the clinical nurse manager and the senior registered nurse have completed at least eight hours of education in the last year to maintain their practising certificates.</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 the temporary absence of the clinical nurse manager, a senior registered nurse is available and experienced to cover the service. The support assistant is also able to provide support when required around other aspects of operational management.</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 Moderate	<p>The quality and risk management programme identifies objectives for the service (refer 1.2.1.1).</p> <p>Activities within the quality and risk management programme include health and safety, adverse event reporting, infection prevention and restraint minimisation. There are policies in place that have been reviewed at least two yearly however documentation of links to legislation and evidence is required. Policies are also required to include reference to changes in practice such as interRAI, Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 and pressure injuries. A document control system is implemented.</p> <p>Quality related data and outcomes are collated. There are meetings held to discuss issues however there is a lack of documentation in meeting minutes evidencing clinical review and discussion. Staff interviewed describe understanding and implementing the quality and risk management programme. There are three to four monthly resident and family meetings with evidence of discussion. Corrective action plans are documented however there is not always evidence of resolution.</p> <p>There is an internal audit schedule that is implemented with risk assessments documented for some areas of risk. The support assistant has completed the risk assessments in the past and these have included observation of a care staff, feedback from the resident and family member and a review of aspects of care for that individual. There have also been risk assessments of areas of service delivery such as human resources, food services, security, restraint, falls,</p>

		<p>manual handling, infection control, emergency services, waste management and resident potential abuse or neglect. The continuation of these and the development of an internal audit around resident files would serve to monitor quality of service delivery and outcomes for residents.</p> <p>Health and safety requirements are being met, including hazard identification. Managers, staff, residents and family can describe input into the health and safety programme through relevant meetings and through discussions with the clinical nurse manager or support assistant.</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 Moderate</p>	<p>There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that most incidents and accidents are being reported, although some identified in progress notes are not recorded using the incident reporting process.</p> <p>The incident forms that have been completed show evidence of immediate responses, investigations and remedial actions being implemented as required. Not all incidents that are unwitnessed or that include an injury to the head show that neurological recordings are taken for a sustained period. This includes reporting to family members and informing the general practitioner. The review confirmed that documented incidents and accidents were closed in a timely manner with actions taken to address issues raised.</p> <p>The clinical nurse manager understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. Not all reporting has been completed as per contractual specifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There is an established system in place for human resource management.</p> <p>All staff records reviewed include an employment agreement and a position description. Staff have criminal vetting prior to appointment and professional qualifications are validated. All staff receive an orientation and participate in ongoing education when this is offered. Performance appraisals are completed for all staff who have been employed for 12 months or more.</p> <p>There is a registered nurse in charge on each shift. Files of registered nurses reviewed hold current first aid certificates. The clinical nurse manager and one registered nurse are interRAI competent. Medicines are given by registered nurses and caregivers who have been assessed as competent. Staff administering medicines maintain competency which is assessed annually by a registered nurse who has been assessed as competent. Staff participate in meetings and also confirm that they are kept up-to-date on changes occurring within the service or matters of</p>

		concern through handover and open dialogue with the clinical nurse manager.
<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 process for determining provider levels and skill mix is defined in policy and considers the layout of the facility and levels of care provided. The clinical nurse manager develops staff rosters. Rosters and staff interviewed and observation on the days of audit confirmed there were sufficient numbers of staff in each area to meet minimum requirements as specified in the Aged Residential Care Agreement. Registered nurses are on duty each shift and are supported by caregivers including staff who have been working in the service for over 10 years. The clinical nurse manager is on site Monday to Friday and on call for clinical emergencies/concerns. Both the clinical nurse manager and a registered nurse live on the same site as the rest home and hospital and both state that they would respond immediately in the event of an emergency.</p> <p>There is a staff member on duty with a current first aid certificate on each shift.</p> <p>The service recently has had resignations of three registered nurses (retirement and home based reason for leaving). The service has had difficulty recruiting into the positions due to the isolation of the service however there is now a full compliment. The clinical nurse manager has been covering shifts with some night shifts in September noted as not having a registered nurse in the building. The clinical nurse manager states that a senior caregiver was on duty during those times and the clinical nurse coordinator was available within one minute of the call being made. The service has a full complement of orientated registered nurses.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>Paper-based resident records are maintained for each resident. All records are maintained confidentially. The resident records are stored in a locked cupboard in the nurse's station with other information kept in the clinical nurse manager's office and in the support assistant's office. The files record information for ongoing care and support being provided. Records are not integrated.</p> <p>Staff have a password to access any electronic files with a back of information kept off site.</p> <p>A record of past and present residents is maintained electronically. InterRAI assessments are completed by the registered nurses and inform the development of the resident's plan of care (refer 1.3.4). Progress records are clearly documented by the staff in the paper-based record. The date, time, signatures and designation of those entering into the records is legible.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Entry criteria, assessment and entry screening processes require review (refer to 1.2.3). There is a support officer employed at the facility who is responsible for liaising with referral agencies and supporting family and residents prior to admission and on admission to the facility.</p> <p>The facility information pack is available for residents and their family and contains all relevant information.</p> <p>The residents' admission agreements evidence resident and /or family and facility representative sign off. The needs assessments are completed for rest home and hospital level of care. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.</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>There is communication between families and other providers, that demonstrate transition, exit, discharge or transfer plans are communicated, when required. Residents' files sighted that required correspondence following transfer and discharge to and from DHB had evidence of the relevant discharge information.</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>Medication area, including controlled drug storage evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks, however six monthly physical stock takes have not been conducted. The medication fridge temperatures are conducted and recorded. Medication management policy requires review (refer to 1.2.3).</p> <p>All staff authorised to administer medicines have current competencies. The medication round was observed and evidenced the staff members were knowledgeable about the medicine administered and signed off, as the dose was administered. Staff education in medicine management is conducted.</p> <p>Medicine file evidences residents' photo identification, however these are not dated. As required (PRN) medication is identified for individual residents, however the indications of use are not consistently recorded. Three monthly medicine reviews and discontinued medicines require to comply with legislation, protocols and guidelines. There were no residents self-administering medicines at the facility.</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>PA Low</p>	<p>The food service policies and procedures require review (refer to 1.2.3). There is a four week seasonal menu reviewed by a dietitian.</p> <p>In interview, the cook and two kitchen hands confirmed they are aware of the residents' individual dietary needs. The residents' dietary requirements are identified, documented and reviewed on a regular basis, however not all residents' files evidenced the dietary requirements in residents' files as they were filed (refer to 1.2.9). The kitchen staff stated they are informed if resident's dietary requirements change.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. A resident with recorded weight loss was provided with nutritional supplements. Some residents' files evidenced residents' dietary intake monitoring. In interviews, residents stated they are satisfied with the food service, reported their individual preferences are met and adequate food and fluids are provided.</p> <p>The fridge, chiller and freezer temperatures are recorded. Food temperatures are taken once a week. Decanted foods are not dated. Pantry selves do not meet infection control standards.</p> <p>Kitchen staff are aware of kitchen cleaning requirements and interviews confirmed a cleaning schedule is followed, however there is no sign off by staff this has occurred.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The clinical nurse manager stated that a process to inform residents and family, in an appropriate manner, of the reasons why the service had been declined would be implemented, if required. The residents would be declined entry if not within the scope of the service or if a bed was not available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>The service has processes in place to seek information from a range of sources, for example; family; GP; specialist and referrer, confirmed at staff interviews. Residents' files did not consistently document the required initial assessments were completed on admission or reviewed when required in both rest home and hospital residents' files. There is one RN who is trained in interRAI assessment process and there was evidence the interRAI assessment have not been conducted within the required timeframes.</p> <p>The residents' files did not consistently evidence residents' discharge/transfer information from the district health board (DHB), where required as these documents were filed (refer to 1.2.9).</p>

		Residents' assessments are conducted in a safe and appropriate setting including visits from the doctor.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The residents' care plans are individualised and up to date, however some documents that support the care plans are not located in the residents' files (refer to 1.2.9).</p> <p>The care plan interventions do not consistently reflect the risk assessments and the level of care required (refer to 1.3.6).</p> <p>Short term care plans are not consistently developed, when required (refer to 1.3.8).</p> <p>In interviews, staff reported they receive adequate information for continuity of residents' care, through staff handover and progress notes. On-going GP care is implemented, sighted in current GP progress reports and confirmed at GP interview (refer to 1.3.3.).</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>	PA Moderate	<p>The residents' care plans do not consistently evidence detailed interventions based on assessed needs, desired outcomes or goals of the residents (refer to 1.3.4 and 1.3.6). The GP documentation and records are current.</p> <p>In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.</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>In interview, the activities officer confirmed the activities programme meets the needs of the service group and the service has appropriate equipment.</p> <p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are completed by the activities officer, however they do not include dates and signatures (refer to 1.2.9). The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data and includes opportunities for spiritual connections. 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.</p> <p>The activities officer reported that residents have opportunities at resident meetings to discuss activities they would like included in the programme. This was evidenced in sighted resident</p>

		meeting minutes. Residents were observed participating in musical singalong provided by external performers, independently reading newspaper, watching television and having visitors throughout the audit. Activities are voluntary and this was evidenced on audit days with some residents choosing not to engage in the planned activities. Residents' attendance records are maintained and the activities officer records residents' involvement in the activities programme in the progress notes.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate	The residents' care plans reviewed were current and reviewed six monthly. Care plan evaluations are documented and record the degree of achievement to the interventions provided. The residents' progress records are entered on each shift. When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans are inconsistently recorded when required. The family are notified of any changes in resident's condition, confirmed at family interviews.
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	There are processes are in place to provide choices for residents in accessing or referring to other health and/or disability services, confirmed at staff interviews. The documents relating to this are not always located in the residents' files (refer to 1.2.9).
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies and procedures for the management of waste and hazardous substances that have a focus on risk management. Waste is mostly of a domestic-type and is managed via a recycling programme or by local council contracted services. Continence product waste is collected by an external contractor. Personal protective equipment for staff is readily available and adequate supplies are maintained for daily use and for use in an emergency situation.
Standard 1.4.2: Facility Specifications Consumers are provided with an	PA Low	The building has a current warrant of fitness. There is a proactive approach to maintenance with no issues identified during the days on audit. Planned and reactive maintenance is implemented

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>by the maintenance person and contractors.</p> <p>The physical environment internally and externally is maintained to minimise risk of harm, promote safe mobility, aid independence and is appropriate to the needs of the current residents.</p> <p>The electrical equipment is checked and records maintained with this including testing of resident property. Testing and calibration checks of medical measuring equipment is expected to occur annually.</p> <p>The service is able to transport residents to appointments and other engagements if required.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are sufficient toilets, hand basins and showering facilities available for residents.</p> <p>There are appropriate privacy protections in place when showers and toilets are in use.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All residents have their own room. There are three rooms on the certificate that allow for two residents however these are used as single rooms unless a couple choses to use these. All rooms are identified as dual purpose with easy hoist access if required. There is ample room for mobility aides to be used safely in each resident's room.</p> <p>Residents and family interviewed state that they can bring in their own furniture when they come into the service.</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>There is a large lounge/dining area. in all units including the dementia unit. There are smaller rooms available throughout the building with comfortable seating for family/visitors and group meetings. The lounge is used for activities. There are deck areas for residents to use and garden areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry</p>	<p>FA</p>	<p>There are separate laundry and linen service policies and procedures available with these</p>

<p>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>reviewed over the past year. These contain all relevant cleaning and laundry policies and procedures to guide staff. There is a large laundry on site that contains commercial grade washing machines and a clothes dryer and there is an outside washing line which is used as much as possible. There is dirty and clean separation in the laundry.</p> <p>The service employs cleaners and laundry staff. Staff observed around cleaning and laundry confirmed knowledge of processes. There is adequate storage for all chemicals in locked designated areas.</p> <p>There are material data sheets available for all chemical products used for cleaning and the laundry. The clinical nurse manager and the support assistant monitors the cleaning and laundry service through the internal audit programme to ensure resident and relative satisfaction is maintained.</p> <p>Residents and relatives interviewed confirm satisfaction with the cleaning and laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an approved evacuation scheme. A planned emergency evacuation has occurred at six monthly intervals. All staff have completed education on emergency management.</p> <p>In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare battery lights, a gas barbecue, linen, continence products, torches and batteries, water and blankets. Food dry stock and frozen food are available for at least three days.</p> <p>An electric call bell system is available throughout the three units. Security is maintained. Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately. The clinical nurse manager, support assistant, person on call or emergency services can be contacted if staff are concerned or if an emergency occurs. Staff are able to describe access to emergency services.</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 bedrooms have an external window that can be opened for ventilation. The buildings are ventilated by opening windows and doors and extraction systems. Heating is managed by use of heaters in the hallway with some residents having individual heaters in their rooms. Residents and family state that the facility is warm in winter and cool in summer.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control (IC) policy and procedures provide information and resources to inform staff on infection prevention and control (refer to 1.2.3). The infection control coordinator (ICC) is the clinical nurse manager, with a position description for this position. Infection are reported at staff meetings (refer to 1.2.3). The IC programme is reviewed quarterly.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICC has access to relevant and current information which is appropriate to the size and complexity of the service. The IC is an agenda item at staff meetings, evidenced during review of meeting minutes and interviews with staff (refer to 1.2.3).</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 IC policies and procedures are documented, however require review (refer to 1.2.3). They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interviews. IC policies and procedures identify links to other documentation in the facility.</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>The infection control education is provided to all staff, as part of their orientation and as part of the on-going in-service education programme. In interviews, staff advised that clinical staff identify situations where IC education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted.</p> <p>The IC staff education was provided by the CNM. The clinical nurse manager has completed relevant infection control education.</p> <p>Education sessions have evidence of staff attendance/ participation and content of the presentations.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The clinical manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.</p> <p>Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the infection control meeting.</p> <p>When infections were sighted as occurring in files reviewed, these were checked in surveillance data. All were recorded and data used to review outcomes both for the individual and the facility.</p> <p>The infection control coordinator is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at staff meetings (refer to 1.2.3).</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files evidenced the residents' who were diagnosed with an infection did not always have short term care plans (refer to 1.3.8).</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RN's, verbal handovers and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded, however the policy requires review (refer to 1.2.3). There were six residents at the facility using enablers and three residents using restraint at time of audit. There is evidence that staff use strategies to minimise restraint and restraint practices are the last resort.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and</p>

		management interviews.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	The facility has a process for determining approval of the types of restraint used and this is implemented when required. RN completes a restraint assessment prior to commencement of any restraint. Care staff are responsible for monitoring and completing restraint forms when the restraints is in use.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	Restraint assessments are completed by the RN and include all relevant areas. The residents' files reviewed of residents using restraint evidenced completed assessments.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	Strategies are implemented prior to use of restraint to prevent the resident from incurring injury, confirmed at staff and management interviews. Restraint consents are signed by appropriate staff and family/ resident. The restraint register is maintained.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Each episode of restraint is evaluated for its effectiveness and need of continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters.</p> <p>Each episode of restraint is evaluated for its effectiveness and need of continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p>	FA	The individual resident's restraint reviews and restraint register updates are conducted. Staff interviews confirmed their awareness of the residents who require restraint and the residents who requested the use of enablers. The staff meeting minutes do not consistently record

Services demonstrate the monitoring and quality review of their use of restraint.		discussions on restraint (refer to 1.2.3). Residents' progress notes evidence restraint is monitored and evaluated at each shift, when in use.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	Resident records include advanced directives with a decision made around competency of the resident by the general practitioner. At times, there is a ‘not for resuscitation’ decision made however the advance directive is not signed by the resident.	In one of eight advanced directives, the person who had enduring power of attorney had signed the advanced directive, and in the other three advanced directives reviewed, an old form was used that did not clearly document the competency of the resident.	Ensure all advance directives where the resident is deemed competent are signed by the resident. 180 days
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals	PA Low	There is a partially documented strategic, business and quality plan that includes goals for the service. There is also an organisational risk management plan that identifies key risks and strategies to mitigate or	The organisational plans are not detailed sufficiently to include actions, accountabilities and timeframes with evidence of review	Complete documentation of current plans and

of the organisation are clearly identified and regularly reviewed.		eliminate risks.	at regular intervals.	review at regular intervals throughout the year. 180 days
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	Policies and procedures are documented and reviewed at least two yearly. Links to legislation and evidence and best practice are not documented and the policies do not reflect changes in practice.	Policies and procedures do not link to legislation and do not reflect changes in practice.	Review policies to reflect links to legislation and changes in practice 180 days
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Moderate	<p>There are a range of meetings held to discuss quality data including quarterly staff, registered nurse and caregiver meetings and monthly head of department meetings (kitchen, maintenance, clinical and support assistant input). Quality data is tabled at relevant meetings. There is a lack of documentation showing discussion of issues.</p> <p>Internal audits are completed as per schedule however an audit of resident files is not completed. Audit results show few findings however at times, there are comments made regarding service provision, Risk assessments are carried out however these are not always completed as per schedule. The risk assessments have been successful in identifying any improvements required in quality of service delivery.</p>	<p>Meetings are not fully documented to include evidence of clinical discussion, practice and to show discussion of all aspects of quality and risk management.</p> <p>Risk assessments are not always carried out six monthly as per schedule.</p> <p>An internal audit of resident files is not completed.</p>	<p>Ensure that discussion of clinical aspects of care, practice and discussion of quality data and risk management information occurs and is documented.</p> <p>Continue to implement the six-monthly schedule of</p>

				<p>risk assessments.</p> <p>Develop and implement an internal audit of resident files.</p> <p>90 days</p>
<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	Corrective action plans are documented however there is not always documentation of resolution of issues.	There is not always documentation of resolution of issues particularly when issues are identified at meetings.	<p>Ensure that there is resolution of issues in a timely manner.</p> <p>180 days</p>
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Moderate	The clinical nurse manager understands the need to report to external authorities. The issues related to staffing have been reported to the funder however HealthCERT has not been informed. Pressure injuries have not been reported to HealthCERT as per expectations.	Reporting to external authorities has not been completed as per contractual specifications.	<p>Ensure that any requirements to report to external authorities are met.</p> <p>60 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</p>	PA Moderate	Not all incidents that are unwitnessed or that include an injury to the head show that neurological recordings are taken for a sustained period.	<p>Not all incidents that are unwitnessed or that include an injury to the head show that neurological recordings are taken for a sustained period.</p> <p>Incident forms are not always</p>	<p>Monitor the condition of any resident who has an unwitnessed fall or where</p>

identify opportunities to improve service delivery, and to identify and manage risk.			documented as part of the adverse event reporting process.	there are injuries to the head for a sustained period. Ensure that all incidents and accidents are documented by staff according to policy. 90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	In the past there has been education for staff with a record maintained of staff attendance. Some education has been offered to staff in 2015 and 2016. A training plan is documented.	Staff have not had sufficient training over the past two years to include clinically based topics and changes to policy and procedure.	Review and implement the annual training plan to include clinically based topics and changes to policy and procedure. 180 days
<p>Criterion 1.2.9.10</p> <p>All records pertaining to individual consumer service delivery are integrated.</p>	PA Low	Each resident has an individual record. This includes a file with the current information and a box of other information such as archived records, previous care plans and other information. The box does not include information that is sorted and while accessible, this is not ordered making it difficult to locate information. The boxes are kept in the support assistant's office and this is locked when staff are not using the office. Incident forms are kept in a separate area and not	Resident records are not integrated.	Ensure that relevant information is kept in an individual file. 90 days

		<p>integrated with resident information.</p> <p>There is a medication file kept with the medications and this is appropriate for the service.</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>The medication chart reviews evidence a small residents' photo identifications are all located together on one page, at the opening of the medication folder with residents name below each photograph. There is no recorded evidence of when these photos were taken.</p> <p>The medication charts comprise of a pharmacy typed medication chart and as required (PRN) medicine chart that is at times prescribed by the GPs. The PRN medicine chart does not record the PRN medicines indications of use (eight of the fourteen medicine charts). Where medications were discontinued there was evidence the medicine was crossed out and signed by the GP, however this was not dated (three of fourteen medication charts).</p> <p>The three monthly medication reviews are recorded on the residents' medication charts, however in three out of fourteen charts reviews had not occurred three monthly.</p> <p>The controlled drug register evidences weekly checks, however six monthly stock takes have not been conducted.</p>	<p>Not all aspects of the medication management system comply with legislation, protocols and guidelines, such as: six monthly stocktakes of controlled drugs; residents' photos not dated; dating of discontinued medications not recorded; three monthly medication reviews; and as required medication do not consistently record indication of use.</p>	<p>Provide evidence the medication management system complies with legislation, protocols and guidelines.</p> <p>90 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with</p>	<p>PA Low</p>	<p>Decanted foods are not dated.</p> <p>Food temperatures are taken by kitchen staff prior to serving food once a week. It was observed, the food was placed on meal trays for residents who required assistance with food and the time taken to present the food was around 20 minutes from serving to</p>	<p>Not all aspects of food service comply with current legislation and guidelines, such as: dating of decanted foods; monitoring of food temperatures; cleaning schedule staff sign off; and maintenance of</p>	<p>Provide evidence all aspects of food service comply with current</p>

current legislation, and guidelines.		<p>presentation to residents. Not all plated food was observed to be covered during transportation. Residents interviewed stated sometimes food is not as warm as they would like, however staff heat the food if this is requested.</p> <p>There is a kitchen cleaning schedule in place and kitchen staff interviews confirmed staff are aware of the kitchen cleaning requirements, however there is no recorded evidence this is occurring.</p> <p>The pantry shelves are painted and in some places the paint has peeled off.</p>	pantry shelves.	<p>legislation and guidelines.</p> <p>180 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>	PA Moderate	<p>Interview with the GP confirmed they are informed of new admission to the facility. The residents' files reviewed evidenced the GP initial assessments were not consistently located on the residents' files and had been filed in the support officers' office (refer to 1.2.9). External correspondence from referrers and specialists was also not located on some residents' files reviewed. The GP initial assessments are not consistently completed within the required timeframes.</p>	GP initial assessments are not consistently completed within the required timeframes.	<p>Provide evidence the GP initial assessments are completed within the required timeframes.</p> <p>60 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>	PA Moderate	<p>Pain assessments for residents experiencing pain have not been recorded on admission or when pain had altered (four of seven files reviewed). Pressure areas risk assessments have not been completed on admission or when change in condition had occurred (two of the seven files reviewed). Wound assessment and wound care plan for a resident with sacral pressure injuries had not been completed.</p> <p>One of seven files reviewed had a completed interRAI assessment.</p>	The initial and ongoing risk assessments are inconsistently completed, including interRAI.	<p>Provide evidence that initial and ongoing risk assessments are completed</p> <p>30 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>There were three residents (two hospital and one rest home) with pressure injuries. One hospital resident with two sacral injuries had no wound assessment or wound care plan or dressing being completed. The three residents with pressure injuries did not have recorded evidence of use if appropriate equipment and nursing plan of care such as 2 hourly turns.</p> <p>Wound care assessments and plans reviewed, evidenced good practice was inconsistently followed for wound care in the use of betadine in six of the eight wound care plans reviewed.</p> <p>Risk assessment finding (when completed, refer to 1.3.4) are inconsistently recorded on the long term care plans, such as pressure injury assessments and the required intervention to support the needs.</p>	<p>The interventions required to address residents' needs are inconsistently documented on care plans and wound care plans.</p>	<p>Provide evidence the care plan interventions are consistent in meeting residents' assessed needs.</p> <p>30 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Moderate</p>	<p>Short term care plans were in some of the residents' files and in the filled boxes (refer to 1.2.9). Four of the five residents' files reviewed with current short term problems did not have short term care plans in place. Two of the seven residents' files did not require short term care plans. The short term problems were recorded in the residents' progress notes, however there were no details of short term goals or intervention or resolution of the short term problem.</p>	<p>Short term care plans are not consistently completed for short term problems.</p>	<p>Provide evidence short term care plans are completed for short term problems.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>There is a process to ensure that medical equipment is calibrated.</p>	<p>The last calibration of medical equipment occurred over a year ago.</p>	<p>Ensure that medical equipment is calibrated annually.</p>

				90 days
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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.