# Graceful Home Limited - Rose Lodge Rest Home

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Graceful Home Limited

**Premises audited:** Rose Lodge Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 7 December 2016 End date: 7 December 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:** 13

# 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 |
|  | 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 |
|  | 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

This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. Rose Lodge Rest Home can provide care for up to fourteen residents with an occupancy of thirteen on the day of audit.

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

The managing director is responsible for the overall management of the facility with a registered nurse providing clinical oversight.

Improvements are required to advance directives; documentation for volunteers; assessment of residents; food services; maintenance; an evacuation scheme; a call system for one room and emergency supplies.

## 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. |

Staff have knowledge and understanding of the rights of residents and consumer rights legislation. Services are provided in a manner that includes residents’ rights. The privacy of residents is respected. Residents who identify as Māori have their needs met. The individual values and beliefs of residents are documented and respected by staff. Staff communicate effectively with residents and their families and friends. Open disclosure is practiced. Consent is sought verbally and in writing from residents where appropriate. Residents have access to advocacy services. Information on advocacy services is available to residents and relatives. Staff encourage residents to maintain links with their family/whanau and community. There is a system of complaints management in place.

## 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 managing director develops and monitors the business risk management plan. The managing director is supported by a nurse manager and another registered nurse both of whom are employed to provide 20 hours a week of registered nurse cover whether onsite or on call. There is a documented quality and risk management system in operation. Assistance in policy development is provided by an external contractor. There is an established system of adverse event reporting in place and the managing director understands statutory and contractual reporting requirements. Human resource management processes for staff are in place. Staff records reviewed showed evidence of accepted human resource practices. Staffing levels meet the minimum requirements specified in the agreement for aged residential rest home level care. Resident information is managed confidentially. Resident files are a mix of electronic and paper-based records with the primary record being paper-based. The nurse manager is trained to use the interRAI software.

## 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. |

Each stage of service provision is developed with resident input and coordinated to promote continuity of service delivery. The residents confirm their input into care planning.

Admission agreements are documented and there is a process for documenting assessments. Each resident has a care plan that includes interventions as per individual needs with these reviewed six monthly. Care plans are updated as changes occur.

Residents and family confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Staff responsible for medicine management have current medication competencies. Staff administered medications as per policy during the audit with medicines kept in a secure area.

Food, fluid, and nutritional needs of residents are catered for with additional dietary requirements provided as required.

## 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 medium or high risk and/or unattained and of low risk. |

The building has a current building warrant of fitness. It consists of two buildings, one of which is the main building. There is an external building situated close to the house which includes the laundry, management office, and one bedroom with an adjourning ensuite. The sprinkler system is joined together by a pipe and covers both buildings. Waste and hazardous substances are managed appropriately. There are adequate communal hand basins, toilets, and showers in the main building. The rooms’ sizes are adequate to meet the needs of rest home residents. There are communal areas for dinning, recreation and relaxation. Cleaning and laundry services are performed onsite by health care assistants. The building has plenty of natural light, safe ventilation and heating systems to ensure the temperature is maintained within a comfortable range for residents.

## Restraint minimisation and safe practice

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

Restraint policies and procedures include definitions of restraint and enablers, which are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. The registered nurse and staff state that restraint is not used in the rest home and there were no enablers used during the audit.

## Infection prevention and control

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

Infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. Infection control is an agenda item at staff meetings with surveillance of infections occurring.

## 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 | 1 | 2 | 4 | 0 | 0 |
| **Criteria** | 0 | 83 | 1 | 4 | 5 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Staff receive training in the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights’ (ie, the Code) at orientation and during refresher training. Interviews with staff confirmed they had an understanding of resident rights. The health care assistant and the nurse manager were observed interacting respectfully and communicating appropriately with residents. Residents are encouraged to make choices. Residents interviewed were able to verify that their rights are upheld by staff. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Negligible | 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 confirmed that consent issues are discussed with them on admission and appropriate forms are shown to them at this time and thereafter as relevant. All residents' files reviewed included written consent.  All residents have the choice to make an advance directive however the documentation of advance directives should be reviewed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | There are appropriate policies in place and brochures on display regarding advocacy support services. Residents interviewed confirm that advocacy support is available to them if required. Staff interviewed have an understanding of how residents can access advocacy support persons. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents have access to visitors of their choice at any time of the day and evening. They are supported to access services within the community and to maintain their links with family and friends. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and procedure refers to the Code and include timeframes for responding to a complaint. Complaint forms are available in the facility. Residents interviewed know how to make a complaint.  There is a complaints register in place. There have been no recorded complaints received since the previous audit. There are no concerns that are currently being investigated by external authorities. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and family members have open access to talk to the management and staff at any time.  Residents interviewed confirmed that they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service in the facility’s admission package prior to the resident’s admission.  Information on the Code and the Nationwide Health and Disability Advocacy Service are displayed at the entrance to the facility. Residents interviewed confirm they have access to an independent advocate if needed. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff interviewed were aware of the need to respect the privacy of residents and to respect their belongings. Needs and values of residents are documented.  Residents were observed being treated with respect by staff during the audit and the practice was confirmed during interviews of residents.  Staff were observed keeping doors closed while attending to residents. Activities in the community are encouraged. Staff and family will transport residents to appointments. There was no evidence of any abuse and neglect sighted. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | The service has a cultural safety policy in place. The policy includes guidelines for the provision of culturally safe services for Māori residents. It includes information on cultural awareness, cultural safety, and the importance of whanau.  There are residents in the facility who identify as Māori. Cultural preferences are addressed in plans of care.  Access to Māori support and advocacy services are available from the Nationwide Health and Disability Advocacy Services.  Staff interviewed confirmed an understanding of cultural safety in relation to care.  Staff education on cultural safety occurs. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are being met. Staff interviewed confirmed an understanding of cultural safety in relation to care. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Expected staff practices are specified in their employment agreements and job descriptions. Residents interviewed reported that staff maintain appropriate professional boundaries. Staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes. There are policies in place to guide staff practice. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Systems are in place to promote good practice by staff to ensure residents receive services of an appropriate standard of care. The nurse manager is committed to ensuring that service provision is based on best practice including access to clinical nurse specialists and District Health Board specialists. The policies in use include references to evidence-based research. References to additional documents are included in policies as appropriate. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy and associated procedure is in place to ensure staff maintain open communication with residents and their families. Communication with family members is being documented in residents' records. Incident forms record evidence of communication with the family following adverse events. Residents interviewed confirmed that staff communicate well with them.  Management are able to access interpreting services if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Graceful Home Limited is owned and operated by the managing director who is responsible for the services provided at Rose Lodge Rest Home.  Two agreements for the provision of publicly funded services are in place with Auckland District Health Board (ADHB), which include the aged related residential care services agreement for rest home level care (being provided for 11 residents) and the long term support-chronic health conditions agreement (LTS-CHC). There were no residents receiving care under the LTS-CHC agreement.  On the day of audit there were 14 beds available which were occupied by 13 people. Nine of the 13 were subsidised rest home residents. Two were private paying residents who had been assessed by a needs assessment and service coordination agency (NASC) and the remaining two were private boarders. One of the two privately paying residents was last assessed by a NASC as requiring dementia level services (link 1.3.1). The two boarders were boarding in the main rest home building under private arrangements with the managing director. The two boarders were close in age to the other residents. The managing director reported that neither boarder had been assessed by a NASC. The boarders were receiving food and furnished accommodation and were using the same shared facilities and amenities as the rest home residents.  There is a documented business risk management plan in place, which includes the direction, vision, mission statement, scope of services, objectives and an action plan. The business risk management plan is developed by the managing director in consultation with external business consultants.  The managing director monitors progress against the business plan and consults with external advisors as necessary. An external accountant has financial oversight of the business.  The managing director has been a senior caregiver in a psychogeriatric area for 15 years and owns a home and community support business which is providing care for privately paying consumers. The managing director has completed eight hours plus of education per annum by attending ADHB run training courses.  The nurse manager is a registered nurse who has responsibility for the oversight of all clinical care provided and reports to the managing director. The nurse manager was appointed to the role in December 2014 to provide 20 hours a week of either onsite or on call services. The nurse manager is supported by another registered nurse who is employed 20 hours a week to cover the nurse manager when absent. Both registered nurses have training relevant to aged care and are employed as registered nurses in other aged care facilities. The nurse manager has completed interRAI training. Both registered nurses have completed at least eight hours of professional development in the previous year.  The rest home can provide care for up to 14 residents. Occupancy on the day of the audit was 11 rest home level residents (which includes the one resident who has been assessed as needing dementia level services) and 2 borders. |
| Standard 1.2.2: Service Management  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. | FA | There are systems in place to ensure the day-to-day operation of the service continues if the facility manager is absent. In this situation the facility manager’s role is managed by one of the two registered nurses who are either onsite or on call. The relieving registered nurse covers if the nurse manager is not available. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is a documented quality plan within the business plan which is reviewed annually. Risk management is incorporated within the business plan. The business plan is monitored by the managing director with advice from external consultants and business advisors.  The service implements organisational policies and procedures to support service delivery. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, contracts, and evidenced-based best practice guidelines. The policy around wounds has been updated to include information provided by the Ministry of Health around pressure injuries. New policies and procedures reference interRAI and the changes in health and safety legislation.  Outdated policies are archived on site. There is a formal document control process in place. Documents are reviewed two yearly or earlier when required. All policies are reviewed on an ongoing basis by an external consultant.  The quality and risk management systems include quality improvements, risk and hazard management, resident satisfaction including complaints management, management of incidents and accidents, health and safety management, infection prevention and control, and restraint management. Three residents completed a satisfaction survey since the previous surveillance audit and all expressed satisfaction with service delivery.  Quality improvement data are collected by the activities coordinator/health care assistant/administrator who analyses and graphs the data and evaluates the findings. Results are communicated to staff at the six-to eight weekly quality meeting. Meeting dates are determined so that the maximum number of rostered staff can attend as attendance is not a funded activity for staff. Minutes are available for those staff who do not attend the meetings.  An internal audit programme is implemented by the managing director, the nurse manager or the activities coordinator/health care assistant/administrator. Corrective action plans are documented. A record of internal audits occurs. The internal audits completed since the surveillance audit mirror the schedule in the annual internal auditing programme.  There are bi-monthly resident meetings. Family may attend.  Health and safety policies and procedures are documented along with a hazard management programme. These policies have been revised since the changes in health and safety legislation. There is a hazard register in place. There is evidence of hazard identification forms being completed when a hazard is identified. Hazards are eliminated, minimised or isolated. Health and safety matters are discussed at the quality meeting.  Corrective actions are documented following internal audits or following the patient satisfaction survey on corrective action forms. Corrective actions are also identified following investigations of incidents, accidents and complaints. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | The manager is aware of situations where there is a need to notify statutory authorities and where HealthCERT would need to be notified of a Section 31 adverse event. There have been no such events since the previous surveillance audit.  Staff document adverse, unplanned, or untoward events in order to identify opportunities to improve service delivery, and to identify and manage risk. A review of incidents and accidents for six separate months since the previous audit was conducted. The number of adverse events documented were very low per month or there were none occurring within the month. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | There are policies and procedures in relation to human resources management. A review of five staff records was conducted, which included the nurse manager, the registered nurse, the team leader/health care assistant (who works mainly on the day shift), the activities coordinator/health care assistant/administrator, and a health care assistant (who works mainly on night shift). Each record contained recruitment documentation, reference checks, evidence of police vetting, an employment agreement, a job description, evidence of qualifications, orientation records, and evidence of annual performance appraisals. Professional qualifications are checked by the facility manager who requests the health practitioner to supply a copy of their annual practising certificate. Registered health professionals (including the general practitioner) providing services to Rose Lodge had current practising certificates.  On the day of audit the service was using a volunteer to assist a health care assistant on a morning shift. The volunteer was interviewed. The arrangement had been in place for a short period. She had not been requested to sign any forms by Rose Lodge. There was no record of an agreement between the volunteer and Rose Lodge to clarify the volunteer arrangement that was in place.  The rostering practice was reviewed. The rosters sighted showed that the service meets minimum staffing requirements as outlined in the Agreement.  The nurse manager is an approved interRAI assessor and is aware of the need to meet annual obligations for maintaining competency. The managing director and the other registered nurse have yet to complete interRAI training. The nurse manager is responsible for infection prevention and control and has completed the Ministry of Health infection prevention and control e-learning module. Two of the five health care assistants have level two New Zealand Qualifications Authority (NZQA) qualifications and the activities coordinator/health care assistant/ administrator has completed a level seven NZQA qualification. At the time of audit there were no staff enrolled in NZQA training. .  Staff are provided with performance appraisals annually or earlier if required.  The manager is responsible for management of the in-service education programme, which includes mandatory training for all staff attending the quality meeting. Attendance is recorded. There is an inservice training planner in place, which outlines proposed and actual training provided. A record of training is maintained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a roster policy that includes a roster template. There is always a health care assistant rostered on duty. The managing director is onsite five days a week and if not onsite then on call. The nurse manager (or the relieving registered nurse) is typically onsite two days a week or is on call. Caregivers call the team leader/health care assistant, a registered nurse or the managing director based on the circumstances of the assistance required. Registered nurses are responsible for calling the general practitioner.  There are a total of 11 staff employed, which includes the managing director, two registered nurses, an activities coordinator/health care assistant/administrator, two cooks, and five health care assistants. The service is also using a volunteer (link 1.2 7.3).  Residents state that there are sufficient staff to support them. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Resident information is entered in an accurate and timely manner into an electronic register. Records are both electronic and paper-based. The master record is paper-based. InterRAI information is recorded accurately in the interRAI software programme. However timeliness and process related to interRAI assessments are of concern (Link 1.3.4). The registered nurse enters resident's data into an electronic spreadsheet on the day of admission to the facility.  Residents' information is held securely. Information is not on public display.  Records reviewed were legible. Clinical records are recorded appropriately. Historical records are held on site and accessible. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | PA Moderate | Entry and assessment processes are recorded. Information is communicated to residents, family, relevant agencies and staff. The admission agreement defines the scope of the service and includes all contractual requirements.  Residents confirm the admission process is completed in timely manner with family engaged in the admission process when at all possible noting that there are few family members engaged with residents in the service. A new resident interviewed states that they are orientated to the site and introduced to other residents and staff on the first day.  All residents except for one has a needs assessment completed prior to admission to the facility with this held in the resident file. Admission agreements are completed on admission. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is appropriate communication between families and other providers that demonstrates that transition, exit, discharge or transfer plans are communicated, when required. The residents’ files evidence appropriate records relating to transfers where this is required. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | A medication policy documented is reflective of current safe practice guidelines. The policy identifies that staff who administer medicines must be competent. Caregivers and the registered nurses who administer medications have completed medication competencies for 2016. The staff member observed administering the lunchtime medication complies with regulation requirements.  Medicines are kept in a locked trolley. The medications that require to be stored in the fridge are in the kitchen fridge on a separate shelf in a sealed container. Temperatures are checked weekly with these at an appropriate range.  There are no residents requiring the use of controlled drugs. The registered nurse was able to describe a process for management of controlled drugs that included these being checked weekly by two staff, one of whom is a registered nurse should they be used. As required medications are charted with documentation of indications for use and maximum dose per hour.  One resident is self-administrating medication with a competency completed by the general practitioner confirming that the resident is able to self-administer medication as per the prescription. The medication is in the resident’s unit in a locked box in a cabinet. There are daily checks that the resident has taken their medication and the handover of the new medication is documented weekly. The caregiver on afternoon shift confirmed that they had been reminded to check that the resident had taken their medication.  Resident records reviewed evidenced photographic identification. The photograph in the resident file includes the date of the photograph being taken and confirmation that it is a true likeness. Any allergies or sensitivities are documented on the medical notes and the resident`s medication record. All medications are prescribed individually and signed and dated by the general practitioner. There is no evidence of any transcribing of instructions. The registered nurse checks the medication packs when received from the pharmacy.  All medications are current with expiry dates checked and any expired medication returned to the pharmacy when identified. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Moderate | The rest home uses the summer/winter seasonal menu which has been reviewed by a dietitian in April 2014. Some resident needs have changed since then and a review of the menu is required.  An individual dietary assessment (nutritional status) is completed on admission for all residents which identifies individual needs, allergies and preferences. Morning and afternoon teas are prepared in the kitchen and snacks are available over twenty-four hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the resident`s GP and notifying the kitchen of extra dietary requirements. The service is managed by two cooks over seven days with one having documentation that evidences food safety training. Special diets can be arranged, for example puree, fortified fluids, vegetarian diets or gluten free diets. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | There is a process to inform residents and family, in an appropriate manner, of the reasons why the service has been declined. The residents would be declined entry if not within the scope of the service or if a bed was not available. The registered nurse communicates with the needs assessment service when any issues arise. There have not been any declined entries since the last audit. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | The service has processes in place to seek information from a range of sources, for example; family (if engaged in the service); the general practitioner; specialists and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.  There was evidence of residents' discharge/transfer information from the district health board where required. The facility has appropriate resources and equipment as confirmed through staff interviews and observation of the environment.  Assessments are conducted in a private setting with residents seen in the rooms. Residents confirm their involvement in assessments, care planning, review, treatment and evaluations of care. Staff interviewed can identify needs of residents as per the assessments completed.  InterRAI assessments are being documented with all residents having an interRAI assessment on file noting that an improvement is required to documentation of interRAI assessments. The registered nurse has completed interRAI training. The service is still using special assessments such as the Coombes assessment, falls, dietary and pressure assessments. Other tools are used when required for example a pain scale is used to assess pain. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Residents’ care plans are individualised. Care plan interventions reflect the level of care required.  Staff report they receive adequate information for continuity of residents’ care (refer 1.3.4). The residents have input into their care planning and review.  Resident files reviewed include detailed plans around specific issues when these were identified for example around management of challenging behaviours and support required for activities of daily living. There is evidence of specialist involvement where this is required. Any recommendations made by visiting health professionals such as the mental health service staff are included in the individual resident’s plan. Requests from the general practitioner are included in the care plan with the general practitioner stating that any directions are followed up well.  Short term care plans are well used for short term needs such as infections, dental extraction and challenging behaviours if these are out of the ordinary. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents' care plans evidence interventions, desired outcomes or goals of each resident. The GP progress notes include reviews that have occurred three monthly or according to timeframes documented. Residents confirm that resident’s current care and treatment meets their needs. This documents the date, method of communication, details of the communication and any comments or follow up required.  The registered nurse documents any review of residents with the staff confirming that they are familiar with the current interventions of the resident.  Short term care plans are developed, when required and signed off by the registered nurse. They record the detail of information required. The registered nurse signs these off as completed when the issue is resolved. Progress against the short-term plan is recorded on the short-term care plan and in the progress notes with evidence of resolution of the short-term issue documented.  The registered nurse monitors to ensure all cares have been completed in a timely manner. Vital recordings are taken as per resident need and at least monthly. A review of the forms with attention to specific needs of the resident as identified through interview and through the care plan indicate that residents are monitored as per their individual requirements. One resident, for example, was identified as losing weight and this was investigated with strategies implemented to address. |
| Standard 1.3.7: Planned Activities  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. | FA | The activities coordinator has an allocation of 25 hours in the service per week. The programme is planned with the residents having input through the resident meetings and on a one to one basis. The activities programme is displayed on a weekly calendar with individual assessments, plans and review documented by the activities coordinator. The activities coordinator completes a daily attendance sheet for each resident. Assessments and plans with evidence of review were sighted in all resident files reviewed.  Regular exercises are provided and the programme includes intellectual activities, spiritual activities, input from external agencies and supported ordinary unplanned/spontaneous activities including celebrations and celebrations. The programme reviewed is implemented ensuring the strengths, skills and interests of residents are maintained. Residents are encouraged to maintain activities in the community.  Residents report they are happy with the activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Periods in relation to care planning evaluations are documented. Residents confirm their participation in care plan evaluations.  The residents’ progress records are entered in at each shift and as changes occur. When resident’s progress is different from expected, the RN contacts the GP as required as confirmed by the two registered nurses and general practitioners interviewed.  There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required. |
| 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 | Appropriate processes are in place to provide choices for residents in accessing or referring to other health and/or disability services. Residents’ progress notes confirm that relevant processes are implemented with appropriate referrals made. |
| 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 documented processes for the management of waste and hazardous substances in place. Policies and procedures provide guidance for staff. Material safety data sheets are available. Staff receive training and education on safe and appropriate handling of waste and hazardous substances, including chemical safety.  Facilities are available for the disposal of waste and hazardous substances.  Protective clothing is available for staff to use (eg, gloves and aprons). |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | Rose Lodge owns the service and leases the premises. It is responsible for all internal fixtures and fittings.  The rest home includes two single story buildings. The main rest home can accommodate up to 13 residents. It has 11 bedrooms in the main facility of which two are double rooms. There were curtains rails with curtains separating the spaces in both shared bedrooms. One of the double rooms on the day of audit was shared between a rest home resident and a boarder. The other double room was shared by two residents. There was one empty single bedroom in the main rest home. The external building contains one single bedroom with ensuite, the office, and the laundry. The bedroom was occupied by a resident.  A current building warrant of fitness was displayed, which expires 14 February 2017. There have been no building modifications since the previous audit.  Maintenance is either done by staff or external contractors. The managing director reported that there is a long term maintenance plan that is developed in consultation with the landlord and accountant. There is a reactive maintenance system in place, which is managed by the managing director in consultation with the accountant.  Medical equipment is available, which includes a thermometer and blood pressure equipment. This equipment has been calibrated in the past by an external company however calibration on the day of audit was overdue. Weighing scales require residents to stand unsupported. There was no evidence to show that these scales were purchased within the last year or had been calibrated within that timeframe.  There was no evidence that an electrician had conducted any testing of mobile electrical equipment (ie, testing and tagging).  Staff interviewed confirmed they have adequate access to equipment.  There is an internal courtyard with shade at the rear of the building. The internal courtyard is a designated smoking area and is used by the resident who lives in the external bedroom as the location is directly opposite their room. Another resident was observed smoking on a seat by the front door, which was open. Secondary tobacco smoke was entering the building on the day of audit exposing residents and staff to environmental tobacco smoke. There are grassed areas in the front of the building with shade, and seating.  Hot water temperatures in resident areas are recorded by the cook and by the team leader monthly. Records reviewed indicated that temperature testing was within the accepted temperature ranges for the provision of care to vulnerable residents.  The service owns a company car for transporting residents. The car had a current warrant of fitness and registration. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are an adequate number of communal toilets and showers available throughout the facility, which are in close proximity to the rooms used by residents. There are separate male and female facilities. All residents living in the main building use communal facilities. The rooms in the main building do not have hand basins. The outside room has its own ensuite toilet and hand basin. There is a separate toilet for use by staff and visitors.  The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned with the exception of the maintenance issues identified above (link 1.4.2.1). |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | With the exception of two bedrooms in the main building, the remaining bedrooms are single accommodation. Bedrooms provide adequate personal space to move around within the room safely. Resident’s bedrooms are personalised to varying degrees. . |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is room for entertainment, relaxation and dinning in the rest home and there are external areas available. Residents were observed moving freely within these areas. On the day of audit the lounge and dining room did not contain seating for 14 residents. Staff reported that some of the residents never eat in the dining room and prefer to eat in their rooms. Staff report that if they did wish to use the dining room then additional chairs would be provided. Additional chairs are taken into the lounge when needed. The group activities programme is provided in the lounge area. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning policy and procedures and laundry policy and procedures are available.  Laundry is performed by caregivers on the morning and afternoon shifts seven days a week. All linen is washed on site in the main laundry, which is located in the external building. There is a clean and dirty flow in place in the laundry.  Chemicals are purchased at the supermarket. Chemicals are stored in the cleaner’s cupboard, which is locked when not in use.  Cleaning is performed by the caregivers seven days a week.  The effectiveness of the cleaning and laundry services is monitored on an ongoing basis by the managing director and is included in the internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate | The fire evacuation scheme was unable to be located by the managing director on the day of audit. Previous audit documentation referenced an approved evacuation plan.  Staff report that a trial evacuation was held on 26 October 2016. However no record was kept of the actual events that occurred during that trial evacuation.  Documented policies are in place for emergency management. All registered nurses and health care assistants are required to complete first aid training. All five staff records reviewed included evidence of current skills in the provision of first aid including resuscitation.  Emergency and security education is provided to staff during their orientation phase and during refresher training. Staff interviewed confirm recent education on fire management. Staff records sampled provides evidence of attendance at fire safety training. Processes are in place to meet the requirements for emergency management and there is a policy in place. Fire exits are clearly indicated.  There is emergency equipment available. The service has emergency torches, a telephone connected to a landline, a first aid kit, radio, blankets, and carries extra food supplies. The site has only one source of power, which is electricity. The managing director reported that she has an informal agreement with the neighbouring aged residential care facility for the use of alternative power in an emergency and would seek their assistance in an emergency.  The facility carries water for use in an emergency if the water supply was disrupted. However the amount and quality of the water being stored was not acceptable.  The call bell system is electric. The call bell indicator panel is located in the rest home hallway in the main building. Staff use the indicator panel to advise them where a bell is ringing. The resident, who lives in the bedroom with the ensuite that is located outside the main building, does not have a call bell. The existing system does not cover the external areas or the dining room or living room. The current resident living in the external bedroom smokes cigarettes, is mobile, is cognitively aware and can clearly articulate their needs. When interviewed and asked as to how they would contact staff overnight when the external doors are locked, the resident stated that they would go to the front of the building if able and ring the front door bell to attract the attention of staff. The external bedroom has a fire sprinkler system in place and a smoke detector. Staff lock the external rest home doors in the late evenings. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All designated areas used by residents have an external window for natural light. Ventilation is provided by opening windows and doors. The facility uses electricity for heating. |
| Standard 3.1: Infection control management  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. | FA | Infection control (IC) policies and procedures provide information and resources to inform staff on infection prevention and control. This includes guidelines around hand hygiene and standard precautions. The delegation of oversight of the infection control programme is documented in policies and procedures. The infection control coordinator (ICC) is the registered nurse.  There is evidence that the staff meetings include discussion of the infection control programme and in particular of any resident issues and surveillance.  The IC programme has been reviewed annually with this completed in December 2015. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has access to relevant and current information which is appropriate to the size and complexity of the service, including the infection control manual; internet; access to experts and education that the registered nurse completes at least annually.  The staff meeting includes discussion of infection control.  The interview with the registered nurse /ICC confirms awareness of their responsibilities of the position. The visual inspection evidences that there are resources such as paper towels and flowing soap provided. |
| Standard 3.3: Policies and procedures  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. | FA | The IC policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user-friendly format by an external consultant and contain an appropriate level of information. Policies are readily accessible to all personnel as confirmed at staff interviews. The IC policies and procedures are developed and reviewed as changes occur by an external provider. IC policies and procedures identify links to other documentation in the facility. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control education is provided to all staff, as part of their orientation and as part of the on-going in-service education programme. Staff state that care staff identify situations where IC education is required for a resident such as hand hygiene; cough etiquette and one on one education is conducted.  Education sessions are documented with a record of staff attendance maintained. The last training for staff around IC has been provided in 2016. The registered nurse/ ICC has completed IC education relevant to their position on an annual basis through the district health board. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control coordinator is responsible for the surveillance programme. Monthly surveillance data relating to number and type of infections is recorded and there is evidence the data being analysed and evaluated.  Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events with these retained in individual resident files. Staff report they are made aware of any infections of individual residents by way of feedback from the registered nurse, through verbal and written handovers and through documentation in progress notes.  A review of the data over the past year indicates that there are few infections. One resident has a number of infections related to their long-term condition and this is well documented in the resident care plan. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures on restraint minimisation and use of enablers are documented and there are links with the policy for managing challenging behaviour. These are accessible to guide staff actions related to restraint and enabler use.  There is no evidence of restraint or enablers being in use at this facility.  The service has a commitment to a ‘non-restraint’ policy, philosophy and appropriate use of enablers/restraint. Enablers are only used for safety reasons. Staff interviewed understood that the use of enablers is to be a voluntary and the least restrictive means to meet the needs of residents with the intention and/or maintaining of a resident’s independence. Training records evidence training occurs at orientation and is ongoing. The registered nurse is the restraint co-ordinator. |

# 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.

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| **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 Negligible | Resident records include advanced directives with a decision made around competency of the resident by the general practitioner. The way the form is documented leads to confusion around who is signing for the advance directive when the advance directive is reviewed. Currently the registered nurse signs to indicate the advance directive has been reviewed and states that the advance directive has been discussed with the resident. The resident does not currently sign to indicate that they have been engaged in the discussions. | The review of the advance directive does not clearly document that the resident has been engaged in the discussion around review of the advance directive. | Review documentation of annual review of advance directives to ensure that there is clarity around input from the resident into the decision.  180 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | The service was using a volunteer to provide care to residents on the day of audit. The volunteer had been providing services for a short period of time prior to audit. There was no record of an agreement between the volunteer and Rose Lodge to clarify the volunteer arrangements. The volunteer reported during interview that they had not been asked to sign any documents. They reported that they were assisting residents with breakfast from 7 am to 9 am Monday to Friday while the other health care assistant on duty was providing personal cares to a resident (thereby providing unsupervised cares). The volunteer was included in a future draft night shift roster indicating that the arrangement was a possible work trial. | The service was using a volunteer to provide care to residents. There was no formal agreement in place clarifying the volunteer arrangements. There was no evidence of police vetting, reference checking, orientation or health and safety training. | Ensure the volunteer relationship is documented, meets legislative guidelines and protects resident safety.  60 days |
| Criterion 1.3.1.4  Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies. | PA Moderate | Each resident apart from one privately paying resident has a needs assessment in their resident record. One privately paying resident has a needs assessment however one does not. The registered nurse has been asking the needs assessment service to complete an interRAI assessment however they state that the service has said that as they are privately paying, that this is not necessary. | One privately paying resident does not have a needs assessment completed. | Ensure that each resident has a needs assessment completed prior to entry to the service.  90 days |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Moderate | The last review of the menu was completed in April 2014. Resident needs have changed over time and the cook has adjusted the way in which food is presented and what is provided to accommodate some needs. Lettuce for example is not provided for some residents as they are no longer able to chew this and another vegetable is provided instead. | A review of the menu has not been completed since April 2014. | Ensure that the menu is reviewed in line with residents’ needs.  90 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The main cook has completed basic food safety training and other food service training. One other cook does not have food safety training but the managing director states that they are enrolled for training to occur. | One cook does not have food safety training. | Ensure that all cooks have food safety training.  180 days |
| Criterion 1.3.4.2  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. | PA Low | The registered nurse completes a nursing assessment when the resident enters the service. All residents have an interRAI assessment with specialised assessments completed six monthly in line with the review of the care plan. The interRAI assessment is not completed at six monthly intervals and the assessment does not necessarily coincide with the review of the care plan. Needs of the residents are identified using the specialised assessment tools currently if the interRAI is not current (reviewed six monthly).  There are two residents in the service identified as privately paying for the service. One resident reviewed has an interRAI assessment completed however this is not current. | The interRAI assessment is not completed six monthly in line with the review of the care plan. | Ensure that an interRAI assessment is completed six monthly in line with the review of the care plan.  30 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | The premises are leased. Rose Lodge is responsible for all internal fixtures and fittings and some of the external environment. The premises have a current warrant of fitness. Medical equipment is provided for staff and the general practitioner to assist in the provision of care to residents. | Seven maintenance issues were identified as part of the audit. The maintenance issues identified were as follows: (1) there was no evidence that electrical equipment which was non-fixed wired had been subject to testing and tagging by an electrician; (2) the calibration and re-testing date for the thermometer and the sphygmomanometer had expired and there was no evidence that the weighing scales had been calibrated or purchased recently; (3) the floor tiles in the northern bathroom in the area by the hand basin had multiple cracks and the shower chair being used for a resident was gouging the surface of the shower lining in that bathroom (4) there was a hole in the wall in bedroom five which was the unoccupied bedroom; (5) the toilet cistern in one of the southern bathrooms was not firmly attached to the wall; (6) secondary tobacco smoke was entering the building through the open front door and windows creating risk for residents, staff, visitors and contractors. | Ensure the reactive maintenance programme maintains the internal and external amenities, fixtures and fittings in an appropriate condition to meet both consumer and staff needs, and that users of the buildings are not at risk from secondary tobacco smoke.  180 days |
| Criterion 1.4.7.1  Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Moderate | Education for staff on emergency management including fire evacuation practices occurs during orientation and in refresher training. Education on fire evacuation has occurred within the last six months. Emergency equipment and resources are stored on site so that staff can respond appropriately in an emergency. Fire exits are clearly marked in the main rest home building. | The supply of emergency water as identified by the managing director was sighted. This supply of water was stored outside the building in an unsecured container the size of a 40 litre rubbish bin. The water stored on the day was contaminated by insects, looked dirty, and the amount of water was insufficient to meet the hydration and cleanliness needs of residents and staff for at least three days in an emergency. | Ensure the facility carries sufficient amounts of potable and non-potable water so that in an emergency, where the town water supply is unable to be accessed, there is sufficient water stored on site to safely meet the needs of all residents and staff on duty for at least a minimum of three days.  30 days |
| Criterion 1.4.7.3  Where required by legislation there is an approved evacuation plan. | PA Low | The approved evacuation plan was unable to be sighted. However previous audit documentation referenced an approved evacuation plan. The managing director stated she did not recall ever seeing such a document. Staff report that a fire evacuation drill was held as part of staff training on 26 October 2016. However they stated that they made no record of the evacuation and did not record the date, time and the minutes taken for staff and residents to fully evacuate the building. A record of staff who attended the fire evacuation training was documented. The facility manager was unsure whether the results of the fire drill had to be notified to the NZ Fire Service, as may be documented in the evacuation plan. | An approved evacuation plan was unable to be sighted on the day of audit although reference to such a plan exists in previous audit documentation. There was no documented record of the recent fire evacuation drill that included a record of the date, time and the minutes taken for staff and residents to fully evacuate the building. | Ensure a copy of the approved evacuation plan is obtained and implemented including the owner’s responsibilities regarding the conducting of trial evacuations.  90 days |
| Criterion 1.4.7.5  An appropriate 'call system' is available to summon assistance when required. | PA Moderate | Call bells are located in bedrooms 1 to 11, the female and male toilets, and in the communal bathrooms. Staff report they can visually see residents in need in the dining room and lounge from the nurse’s station, which is located in the dining room opposite the lounge. However there is often only one healthcare assistant on duty. The functionality of the call bell system is included in the internal auditing programme. | There is no call bell system installed in the external bedroom with ensuite, or the dining room and lounge in the main building. | Ensure there is an appropriate call bell system installed that enables all residents to be able to summon assistance from staff when required.  30 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.