

Lara Lodge 2017 Limited - Lara Lodge

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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: Lara Lodge 2017 Limited

Premises audited: Lara Lodge

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 23 February 2017 End date: 23 February 2017

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 19

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.

General overview of the audit

Lara Lodge is a privately owned aged care facility. The service provides care for up to 27 residents requiring rest home level care. On the day of the audit there were 19 residents.

A provisional audit was conducted to assess a prospective new owner for the facility and to assess the status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff management and the prospective purchasers.

An interim nurse manager is currently overseeing the service, and has previous aged care management experience. The interim manager, will be remaining in the position with the new owners. The new owners have had previous ownership and experience in the health and disability sector. They will continue to use the current Lara Lodge policies and procedures to guide staff. It is the

new owner's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership.

The service has not yet addressed the four shortfalls from the previous certification audit. Improvements continue to be required in relation to adverse event reporting, InterRAI assessments, medication management, and hot water temperatures.

This audit identified that improvements are required around the quality programme, orientation/induction, performance reviews, staff training, admission agreements, assessments, evaluations, food services, restraint management, and infection control review.

Consumer rights

Lara Lodge provides care in a way that focuses on the individual resident. The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

The family members and residents have been made aware of and fully understand informed consent processes and that appropriate information had been provided.

Organisational management

The new owners of Lara Lodge have previously owned a non-aged residential service within the health and disability sector. The new owners have a transition plan in place to facilitate the smooth transition between owners, with the least disruption of services for staff and residents. This plan includes the ongoing employment of all current staff and the retention of the interim manager as the facility manager.

The service has a documented quality and risk management programme. Staff and residents/family meetings have been held. There are documented health and safety management policies, systems and processes. Incidents and accidents are reported. An education and training programme has been documented. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Residents are assessed prior to entry to the service and initial assessments are completed within 24 hours of entry to the service. The registered nurse is responsible for InterRAI assessments and care plan development with input from residents and family. Planned activities are appropriate to the residents assessed needs and abilities. Residents and a family interviewed confirmed that they were happy with the care provided. There are policies and procedures around safe administration of medicines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and was reviewed at least three monthly by the general practitioner. Residents' food preferences and dietary requirements are identified at admission and all meals cooked on site.

Safe and appropriate environment

There are appropriate policies available in safe use of chemicals along with product safety charts. The building holds a current warrant of fitness. Reactive and preventative maintenance is carried out. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system.

Restraint minimisation and safe practice

Lara Lodge has restraint minimisation and safe practice policies and procedures in place. On the day of audit, there were two residents using a restraint and no residents using an enabler.

Infection prevention and control

The registered nurse and the interim facility manager implement the infection prevention and control programme. Documented policies and procedures are in place for the prevention and control of infections. Infection control education is provided to all staff as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant staff.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	38	0	11	1	0	0
Criteria	0	87	0	12	2	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>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. Staff interviewed (one interim manager, one registered nurse, and four healthcare assistants) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service.</p> <p>Interview with the prospective owners confirmed their understanding of the consumer rights and their obligations to ensure the Code of Health and Disability Services Consumers' Rights and the Nationwide Health and Disability Advocacy Service information is clearly displayed and easily accessible to anyone to whom the information is relevant to. The code is also displayed in Māori.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives were signed-for separately. There is evidence of</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>discussion with family when the GP has completed a clinically indicated not for resuscitation order. The healthcare assistants and the registered nurse (RN) interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. All five resident files sampled had a signed admission agreement and consents signed on or before the day of admission, however admission agreement in use does not align with the ARRC contract (link 1.3.1.4).</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Nationwide Health and Disability Advocacy Service brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.</p>
<p>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.</p>	FA	<p>The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do.</p>
<p>Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of complaints process. There is a complaint form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed could describe the process around reporting complaints.</p> <p>There is a complaint register, which is reviewed monthly. No verbal or written complaints have been received since the last audit. Resident meetings are held monthly and residents are invited to provide</p>

		<p>feedback on the service or raise any concerns they may have at this meeting. The interim manager could describe the process they would follow should the service receive a complaint. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns they may have.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The interim manager discusses aspects of the Code with residents and their family on admission. Five residents and one family member interviewed reported that the residents' rights were being upheld by the service and the staff are very supportive.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting residents' privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.</p> <p>A policy describes spiritual care. The service has visiting clergy who meet with the residents. All residents interviewed indicated that residents' spiritual needs are being met when required.</p>
<p>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.</p>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. Residents who identify as Māori have their cultural needs addressed in the care plans sampled.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review as demonstrated in resident files sampled. Discussions with staff confirm that they are aware of the need to respond to cultural differences.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. This is achieved in collaboration with the resident, family/whānau and/or their representative. Beliefs and values are incorporated into the residents' care plans in resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</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>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the healthcare assistants confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Staff interviewed had a sound understanding of principles of aged care. Residents and family/whānau interviewed reported that they are satisfied with the services received. A resident satisfaction survey is completed annually. The prospective owners stated that they will continue to work within best practice guidelines and comply with all legislative and contractual guidelines.</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>PA Low</p>	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. There are regular resident and family meetings. The residents interviewed advised that the interim manager and staff are very approachable. The accident/incidents, complaints procedure and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensures that full and frank open disclosure occurs, however family were not always</p>

		notified following an adverse event.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Lara Lodge is privately owned and provides care for up to 27 rest home level residents. On the days of audit there were 19 residents, including one resident admitted for respite care. The remaining 18 residents were all admitted under the ARCC.</p> <p>The facility is currently being managed by an interim manager who works 40 hours per week and is supported by a registered nurse. The interim manager is a registered nurse with a current APC and has completed eight hours of professional development in the past 12 months.</p> <p>The prospective owners have previously owned and operated a residential service for people with intellectual disability. The prospective owners currently own another business and one of the owners has had experience in managing a GP practice.</p> <p>The prospective owners have researched the requirements of the ARRC contract and have an understanding of what is required of them. The prospective owners have introduced themselves to relevant personnel within the DHB. There has been a transition plan developed that will allow for a seamless transition for residents and staff. The prospective owners advised that all current staff will be retained and the interim manager will be appointed as the clinical manager.</p> <p>The prospective owners will retain the current purpose, values, scope, direction, and goals of the service and ensure that the purpose, values, scope, direction and goals will be regularly reviewed. The prospective owners will be taking on roles within the organisation (facility manager and public relations/marketing), and will be supported by the current staff. Position descriptions for the prospective owner's roles have been developed. The facility manager job description role is clear that accountability for clinical care remains with the registered nurses. The prospective owners will be available and on call after hours, to ensure that all appropriate requirements for the service, including efficient and effective management of the day-to-day operation of the service and the provision of timely, appropriate and</p>

		safe services to residents is maintained. The tentative settlement date is 16 March 2017. Relevant authorities have been notified of pending change of ownership.
<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	Interviews with the prospective owners and current interim manager, confirmed that there will be no changes to the day-to-day operation of the facility. The interim manager and the current registered nurse provide afterhour's clinical cover and provide leave cover for each other. The prospective owners will live in the area and will be available to the staff 24 hours, seven days a week.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>The service has comprehensive policies/procedures to support service delivery. There is a documented process for reviewing organisational policies and procedures. Staff sign that they have read updates to policies. The 2016 quality and risk plan is not due for review until 31 March 2017. The new owners have documented a quality and risk plan documented for 2017. The 2017 quality plan describes a quality improvement processes for Lara Lodge. The risk management plan describes objectives, management controls and assigned responsibility.</p> <p>Progress with the 2016 quality and risk management programme has been monitored through the monthly quality improvement/staff meetings up to August 2016, however there is no evidence that the quality improvement plan was monitored after this date.</p> <p>An internal audit schedule is in place and all scheduled audits have been completed.</p> <p>Data is collected for falls, complaints, infections, and accidents and incidents. Infection control information is collated, but not consistently analysed and evaluated and used for service improvements. Corrective actions are not consistently documented where quality data identifies opportunities for improvements and corrective actions have not been communicated to staff or signed off when implemented.</p> <p>The service has a low incidence of falls, and staff interviewed were</p>

		<p>knowledgeable about falls prevention strategies. Falls prevention strategies are in place on a case-by-case basis.</p> <p>Resident/relative meetings are held monthly and gather feedback on the service provided.</p> <p>The service has documented health and safety policies. There is a hazard register in place which is due for review in March 2017. Health and safety is covered at orientation for new staff. Staff have had a Health and Safety update in November. Staff interviewed could describe hazard management practices used on site.</p> <p>Interview with the prospective owners confirmed the current quality management system and performance monitoring programme will continue following the sale. The interim manager will help mentor the prospective owners to the quality risk system during the transition period. There are no planned changes to the current policies and procedures.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Incident and accident data has been collected but not consistently analysed or trended (link 1.2.3.6). The interim manager advised they are responsible for investigating accidents and near misses.</p> <p>A sample of eleven resident related incident reports for February 2017 was reviewed. Six of the eleven incident reports sampled (and a review of the clinical file), evidenced that appropriate clinical assessments, care, and care plan documentation had occurred following the incident.</p> <p>Discussions with the interim manager and the prospective owners confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications, including section 31 notifications. The service has a process/policy that reflects the Health and Disability Services (Safety) Act 2001 section 31 reporting guidelines.</p>

		The previous audit finding related to adverse event reporting remains.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed (one interim manager, one registered nurse, one healthcare assistant, one cleaner and one activities person.)</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed could describe the orientation process and stated that they believed that new staff were adequately orientated to the service. Senior staff orientate healthcare assistants through a 'buddy system'. Not all staff files sampled could evidence completion of the required orientation. Annual appraisals have not been conducted for all staff. A completed in-service calendar for 2016 exceeded eight hours annually and an in-service schedule is being implemented for 2017. Attendance records reviewed indicate that in-service sessions are well attended, and cover aspects of care and service delivery related to the rest home level of care. However not all staff have completed chemical safety training. Staff have completed the required organisational competences, which include first aid, medication, and restraint minimisation. The registered nurse is trained in the use of InterRAI.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Lara Lodge policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The interim manager is a registered nurse and works five days per week. There is also a registered nurse who works 40 hours per week. There is a minimum of one registered nurse available on a morning shift seven days per week. There are two care staff rostered on a morning and afternoon shift and one care staff rostered on nights. The interim manager and the registered nurse share on call.</p> <p>Extra staff can be called in for increased resident requirements. The rosters sighted confirmed that staff are replaced on the roster. There</p>

		<p>are dedicated cleaning staff seven days per week and the care staff complete the laundry. The care staff interviewed advised that they have enough time allocated to complete the laundry. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p> <p>The prospective owners stated in the interview that there is no intention to make any changes to staff and all staff will be transferred over to the new owners on the date of settlement. The prospective owners will be taking on the day-to-day facility management with the current interim manager being retained to provide oversight of the clinical aspects of the business. The prospective owners have experience managing staff in the health and disability sector, including staff skill mix and contractual obligations. The prospective owners will also be available to the staff 24 hours, seven days a week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area.</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>	PA Low	<p>Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission. The service has specific information available for residents/families at entry and it included associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. Admission agreements were signed in all five residents' records sampled. The admission agreement reviewed does not align with the ARRC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit,</p>	FA	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. The</p>

discharge, or transfer from services.		completed forms were sighted on file.
<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>There are policies and procedures in place to guide staff in safe medication management. Eleven medication charts were reviewed. They were legible and included photos and identified allergies. Medications received were checked on delivery by the RN. All medications were stored safely. All eye drops were dated on opening. Medication charts had been reviewed three monthly and as needed by a GP. The standing order medications have been reviewed and signed by the GPs yearly and meet the legislative requirements for standing orders.</p> <p>Staff responsible for the administering of medications have completed annual medication competencies and annual medication education. The medication fridge has temperatures recorded daily and these are within acceptable ranges. There were no residents using controlled drugs on the day of audit and the controlled drug safe was empty.</p> <p>Staff signing on 'as required' medication was correct. All 'as required' medications had indication for use identified on the medication chart; all charted medications had been signed and dated. Self-medication is facilitated by the staff, however monitoring of self-administration of medicine is not recorded. The prescribing and administration of anticoagulant drug was not always correct. There is a lack of documented evidence around the RN input in PRN medication administration.</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 include the principles of food safety, ordering, storage, cooking, reheating and food handling. All meals are prepared and cooked on site. A dietitian has reviewed the menu.</p> <p>The cook receives a dietary profile of resident dietary requirements and any likes or dislikes including updates. Special diets including modified foods are provided although only diabetic, pureed and soft diet were required at the time of the audit. Staff were observed</p>

		<p>assisting residents with their meals and drinks in the main dining room.</p> <p>Fridge and food temperatures were monitored and recorded daily. Cooked meals are plated from the kitchen directly to the dining room. All residents are weighed regularly. Residents showing weight loss are provided with food supplements. The current menu has been previously reviewed by a dietitian. On interview, the interim facility manager and the prospective owner stated that they have plans to improve the food services and confirmed that food services are a priority. Food services require improvement and inspection of the kitchen revealed that frozen food was not stored correctly.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The reason for declining service entry to potential residents to the service would be recorded and they are referred back to the referrer to ensure that they are admitted to the appropriate level of care provider. On interview, the interim facility manager stated that Lara Lodge has not declined any resident as they do have vacancies.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RN and the interim facility manager are both InterRAI competent, however all InterRAI assessments are completed by the RN. Initial assessments and risk assessments were completed on admission including risk assessment tools. Resident needs and supports are identified through the ongoing assessment process in consultation with residents and families. InterRAI assessments were not completed in a timely manner in two out of five files reviewed (link 1.3.3.3).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The care plans describe the resident goals, supports and interventions required to meet individual goals or desired outcomes. Specific assessments and care plans for known risks such as diabetes, falls, incontinence, and pressure injury risk assessment and infection control had been well documented. Short-term care plans were documented. Interventions were sufficiently detailed to address the desired outcome/goal. Resident files include all required</p>

		<p>documentation. Care plans evidenced resident (as appropriate) and family involvement in the care plan process. A relative interviewed confirmed they were involved in the care planning process.</p> <p>Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the physiotherapist and mental health services. Integration of records is well managed.</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 Low	<p>Five residents interviewed reported their needs were being met. One relative interviewed stated that her relative's needs were being appropriately met and the family was informed of any changes to health and interventions required.</p> <p>Dressing supplies are available and a treatment room is stocked for use. There was no wound being treated at the time of the audit. Wound assessments and management forms are available when required. The RN interviewed could describe the referral process to a wound specialist or continence nurse. Monitoring occurs for weight, vital signs, and blood glucose as needed. Specialist continence advice is available as needed and this process described by the RN. Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management.</p> <p>Not all assessments following an adverse event had been fully documented and not all neurological observations had been completed as required following an unwitnessed fall.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs an activities staff across five days a week for 4 hours per day. Activities staff were on leave on the day of audit and another staff member undertook the role in her absence. The programme is planned monthly and activities planned on the day were displayed on noticeboards around the facility. An activities plan is developed according to each resident's assessed needs, abilities, previous and current interests. Residents are encouraged to join in activities and community connections are maintained. Residents were</p>

		observed participating in activities on the days of audit. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. One resident stated that by choice, she does not join group activities, however she has regular family support. She uses her computer to play cards and staff and the management provides one-on-one interaction and company on a daily basis.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Care plan evaluations are completed by the RN and the GP notified if the resident requires medical assessment. Short-term care plans were reviewed regularly with problems resolved or added to the long-term care plan if an ongoing problem. The GP conducts a three monthly resident review and medication review. Initial care plans were reviewed by the RN within three weeks of admission. Residents and family were involved in reviewing care. This was noted in the resident's file and one family and five residents interviewed confirmed this.
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 documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and the families are kept informed of the referrals made by the service. The RN and the interim facility manager are on call for emergencies and referrals to other services.
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	All chemicals are labelled with manufacturer labels and safety material datasheets were available and accessible in all service areas. Gloves, aprons, and goggles were available for staff. Chemical safety training has been provided to staff. Chemicals were not stored securely in the laundry but this was addressed during audit.
Standard 1.4.2: Facility Specifications	PA Low	There is a current building warrant of fitness which expires on 13 July

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>2017. Hot water temperatures are checked monthly; however it has not been maintained at 45 degrees Celsius. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been maintained with safe paving, outdoor shaded seating, and deck areas. Interviews with caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. Servicing of equipment has been identified as an issue including wheelchairs and a hoist.</p>
<p>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.</p>	<p>FA</p>	<p>There are sufficient numbers of toilets and bathrooms for the number of residents in the facility. Privacy is assured when residents are receiving assistance. Five residents interviewed stated their privacy and dignity was maintained while attending to their personal cares and hygiene. All bathrooms and toilets are maintained to a good standard, and are easy to clean both walls and floors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>The resident rooms are spacious and residents are able to manoeuvre mobility aids around the bed and personal space. Four caregivers interviewed report that rooms have sufficient space to allow cares to take place. The bedrooms were personalised.</p>
<p>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.</p>	<p>FA</p>	<p>The rest home has three lounge areas and a dining area, which are suitable for the residents and the care setting. The dining room is located directly off the kitchen/servery area. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</p> <p>The dining room and lounges are within easy walking distance to bedrooms. Residents interviewed confirmed they use their rooms or external areas if they want privacy or quiet time. All furniture is safe and suitable for the rest home residents. There is a second floor of the</p>

		building with two bedrooms, a bathroom and a lounge. This floor is currently not utilised due to the number of residents.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The service monitors the effectiveness and compliance of cleaning and laundry policies and procedures. Caregivers are responsible for laundry service and there is a dedicated cleaner. There are sufficient staff allocated to carry out these services. Current safety material datasheets about each product are located with the chemicals. The closed chemical dispensing system is used for chemical safety and staff can access chemicals for cleaning and laundry services (link 1.4.1.1).</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>The service has an approved evacuation plan and fire drills are held six monthly. Staff attendance is recorded in the training records. Civil defence equipment and resources are available. A gas barbecue is also available. The facility has back-up lighting, power and sufficient food, water and personal supplies to provide for its maximum number of residents in the event of a power outage.</p> <p>The emergency plans and security systems meet regulation requirements. The staff are responsible for checking the facility for security purposes on the afternoon and nightshifts. The police would be summoned if and when required. The nurse call system is appropriate for the size of the facility and call bells are accessible in the rooms, lounge and dining areas.</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 communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Resident and family interviews confirmed that the internal temperatures and ventilation are comfortable during the summer and winter months.</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>PA Low</p>	<p>The IC programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. Review of the IC policies and procedures occurred in January 2017. Responsibility of the IC role is clearly identified and understood by all. Resident who has infections has short-term care plans. IC data is discussed in the relevant meetings and during handovers. Staff received training around infection prevention and control. Education was provided for all new staff on orientation. IC audits were completed and required follow-ups were implemented but annual review of the IC programme has not been completed for 2016 yet.</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 RN has undertaken the IC coordinator role since November 2016 and she is supported by the interim facility manager who had completed an external IC training in 2016. There are adequate resources to implement the infection control programme, which is appropriate for the size and complexity of the organisation. The IC coordinator and the interim facility manager described adequate external support from the local laboratory infection control team, GPs and the IC team from the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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>There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated in January 2017.</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>Formal infection control education for staff has occurred. Staff interviewed were knowledgeable around infection prevention and control. Staff interview confirmed that visitors are advised of infections and staff and visitors are advised not to visit or come to work if they</p>

		feel ill. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	The registered nurse is the designated infection control nurse and IC activities overseen by the current interim facility manager. Monthly infection data is collected for all infections based on signs and symptoms of infection or laboratory confirmation. Short-term care plans have been utilised for identified infections. Surveillance of all infections is entered onto a monthly facility infection summary and staff are informed. The data has been monitored and evaluated monthly. There have been no outbreaks since the last audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were two residents using restraint (one resident is using a bedrail and lap belt, and one residents is using a bed rail). There were no resident's using an enabler on the day of audit. The registered nurse is the designated restraint coordinator (interviewed).
<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 registered nurse is the restraint coordinator. The registered nurse has not yet had any training on restraint minimisation and safe practice (link 1.2.7.5). Staff advised that they had received education on restraint minimisation and safe practice (RMSP), enabler usage and de-escalation techniques for challenging behaviours. However, no record of this staff training could be located (link 1.2.7.5). Assessment and approval process for restraint use included the restraint coordinator/registered nurse, resident or representative and medical practitioner. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint is not discussed as part of quality/staff meetings (link 1.2.3.6).
<p>Standard 2.2.2: Assessment</p>	FA	The service completes comprehensive assessments for residents who

<p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>require restraint (or enabler) interventions. These were undertaken by the registered nurse, in partnership with the family/whānau, in the restraint files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>PA Low</p>	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. An assessment form/process is completed for all restraints and enablers. The files reviewed had a completed assessment form and a restraint care plan, however these forms did not always document the risks associated with the use of the restraint and the care plan did not document the interventions required to manage the assessed risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed. The service has a restraint and enablers register, which is updated each month.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented the evaluation of restraint at least every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator. Evaluation timeframes are determined by policy and risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. The restraint coordinator completes reviews.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Staff complete an accident and incident form following any adverse event, and document a summary of the incident in the progress notes. The accident/incident forms in use includes a section to record who was notified (or not) of the event. Six of eleven forms reviewed, (and a review of the progress notes), did not evidence that families/whānau were notified following an adverse event. Staff interviewed stated relatives are always informed.	Six of eleven incident/accident forms reviewed (and a review of the progress notes), did not evidence that families/whānau were notified following an adverse event.	<p>Ensure that family/whānau are notified following an adverse event</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and</p>	PA Low	Infection control data has been collated and the results communicated to staff. Clinical	(i) Quality improvement data is not consistently trended and analysed to identify opportunities	i-iii) Ensure that all quality improvement data is trended and analysed and the results

<p>evaluated and the results communicated to service providers and, where appropriate, consumers.</p>		<p>Indicator data is collected each month for falls, skin tears, medication errors, resident behaviours, health and safety, infections and use of restraint. Accident and incident forms are completed by staff. The quality improvement data captured is not consistently trended and analysed to identify opportunities for improvement and documentation does not reflect that the results are not consistently communicated to staff. The audit schedule has been implemented. There has been no monthly review of the 2016 quality and risk management plan as required by the organisational policy. However, the prospective owners have documented a quality and risk plan for 2017 that will be implemented following the change of ownership.</p>	<p>for improvement. Corrective action plans are not consistently documented where opportunities for improvements are identified.</p> <p>(ii) There is a lack of documented evidence to reflect quality improvement data being communicated to staff.</p> <p>(iii) There has been no monthly review of the 2016 quality and risk management plan as required by the organisational policy.</p>	<p>communicated to staff and residents where appropriate.</p> <p>90 days</p>
<p>Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>The service has a documented orientation programme. The care staff interviewed advised that new staff were sufficiently orientated to the requirements of their role. In the files sampled not all staff could evidence completion of the required orientation.</p>	<p>Three of five files sampled (Interim manager, cleaner and activities) had no evidence of completion of the required orientation programme.</p>	<p>Ensure that the required orientation/induction programme is completed by all staff and evidence of this is kept on staff files.</p> <p>90 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan,</p>	<p>PA Low</p>	<p>There was an education plan documented and implemented for</p>	<p>i) Three of three staff files sampled that were due for an</p>	<p>i) Ensure that all staff have at least an annual</p>

<p>facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>2016. There is an education plan for 2017. Staff training that has been offered has been well attended. A number of care staff have completed National Certificate qualifications. Staff have completed the required organisational competences. Staff working in the kitchen have completed food safety training courses. The laundry is completed by care staff. Annual performance reviews have not been completed for all staff. Staff have completed first aid training, which expires 4 March 2017.</p>	<p>annual review had not had their performance review completed.</p> <p>ii) The restraint coordinator has not attended or received training on the Restraint Minimisation and Safe Practice standard.</p> <p>(iii) Evidence of staff attendance at training in relation to the Restraint Minimisation and Safe Practice standard and management of challenging behaviours could not be located.</p>	<p>performance review.</p> <p>ii) Ensure that the restraint coordinator attends training on the Restraint Minimisation and Safe Practice Standard (2008).</p> <p>111) Ensure that the service can evidence staff training in relation Restraint Minimisation and Safe Practice Standard (2008) and the management of challenging behaviours.</p> <p>90 days</p>
<p>Criterion 1.3.1.4</p> <p>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.</p>	<p>PA Low</p>	<p>Residents' entry into the service is facilitated by the interim facility manager and the RN. Pre-admission information packs include information on the services for residents and families. Admission agreements were signed in all five resident's sampled records. Admission agreements in use do not reflect all the contractual requirements.</p>	<p>The admission agreement does not align with the ARRC contract such as, the payment schedule around re-payment after discharge is not included in the contract.</p>	<p>Ensure that resident admission agreement aligns with the ARRC contract.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration,</p>	<p>PA Moderate</p>	<p>Eleven medication charts were reviewed. One additional chart on top of the 10-sampling group were added to cover anticoagulant medication administration. Nine of 11 medication charts reviewed met</p>	<p>(i) An anticoagulant drug was signed as administered twice a day instead of once a day. There was no medication error reporting following this incident. The RN interviewed and the RN was</p>	<p>(i) Ensure safe administration of anticoagulant drugs and that this is reflected in documentation. (ii) Ensure documented evidence of RN input in PRN medication</p>

review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		legislative requirement. Discontinued medications were dated and signed by the GP. All 'as required' medications had an indication for use. General practitioners prescribe and review medications regularly. A medication round observed, demonstrated appropriate practice. Anticoagulant medication administration has not been completed according to the recognised medication guidelines. There is a lack of documented evidence around the RN input in PRN medication administration.	unable to determine if this was a signing error or if the medicine was administered twice. (ii) Anticoagulant drug charts were faxed to the service from the GP's clinic according to the blood results. An anticoagulant drug chart was missing at one time and another time, the RN had a verbal order but this was not followed with a written instruction by the prescriber. (iii) RN input following PRN medication administration by caregivers was not always documented in the residents' files. For example, a PRN antipsychotic drug was administered seven times in two weeks' but there was no documented evidence in the resident's file by the RN about effectiveness and appropriateness of the PRN medication administration.	administration. 30 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	There are policies and procedures around self-medication administration and residents who wish to self-administer their medicine is facilitated by the service, however monitoring of self-administration of medicines does not occur.	A resident was assessed as competent to administer her own insulin, but there was no documentation to reflect what was being administered. According to Lara Lodge policy, the RN is required to monitor the resident's competency on a weekly basis, this was also not documented.	Ensure that self-medication administration is monitored. 30 days
Criterion 1.3.13.5	PA Low	Food temperatures are checked	(i) Frozen meat was not stored	Ensure that food is stored

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		before serving. Fresh fruit is available (sighted). Interviews with cook confirmed knowledge of food safety requirements. The cook described rotation of foods, temperature checking and safe delivery of frozen foods and dairy based products, but frozen foods were not stored correctly.	correctly. Packaging was open and the meat was discoloured. (ii) Two meat products were taken out of the original packaging and re-packaged in small portions but the date was not recorded on the new package.	correctly. 60 days
Criterion 1.3.3.3 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.	PA Low	InterRAI assessments were completed in a timely manner in three out of five files reviewed. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives in the long-term care plans.	(i) One resident's InterRAI assessment was overdue 35 days and another InterRAI assessment was completed four weeks after admission. (ii) One care plan evaluation was overdue.	(i) Ensure that InterRAI assessments are completed in a timely manner. (ii) Ensure that care plan evaluations are completed at least six monthly. 180 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	The registered nurse completes an assessment of the resident following any adverse event and documents, where required, a short-term care plan for any assessed care needs. Not all assessments following an adverse event had been fully documented and not all neurological observations had been completed as required following an unwitnessed fall.	Two of eleven residents did not have the RN assessment fully documented following an unwitnessed fall and the neurological observations were not completed as required by the organisational policy.	Ensure that all RN assessments are fully documented and neurological observations are completed following an unwitnessed fall according to the organisational policy. 90 days
Criterion 1.3.8.2	PA Low	Two out of five files reviewed showed that care plan evaluations	(i) In one file, a resident with several wandering episodes out of	(i) Ensure care plan evaluations include reviewing

<p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>		<p>were timely, comprehensive, related to each aspect of the care plan and also recorded the degree of achievement of goals and interventions.</p>	<p>the facility were documented in the progress notes but care plan evaluations did not include this and effectiveness of current interventions were not documented in the progress notes. (ii) One care plan evaluation was completed before the InterRAI assessment, and care plan evaluations have not been completed following this assessment.</p>	<p>interventions outcomes. (ii) Ensure InterRAI re-assessments are completed before the care plan evaluation.</p> <p>180 days</p>
<p>Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>The facility is maintained in good repair and ongoing maintenance occurs. Hot water temperatures are checked monthly, but remedial action is not always taken where temperatures are over 45 degrees Celsius. Medical equipment and electrical appliances have been tested and tagged and calibrated but a hoist has not been serviced since 2013 and wheelchairs require servicing or replacement.</p>	<p>(i) Hot water temperature fluctuates around 45 to 51 degrees Celsius. This was recorded as part of the quality system including follow-up requirements around contacting a plumber to rectify the situation; however outcome of this was not documented. Furthermore, there was no documented evidence that hot water temperatures are within acceptable range. (ii) The facility has a sling hoist to be used as required; however it has not been serviced since 2013. (iii) Meeting minutes identified concern about a lack of wheelchairs, as three wheelchairs were requiring replacement or repair. Staff interview confirmed lack of wheelchairs continues at times.</p>	<p>(i) Ensure that hot water temperature is maintained within 45 degrees Celsius. (ii) Ensure that the hoist is serviced. (iii) Ensure that there are adequate numbers of wheelchairs available for resident use.</p> <p>90 days</p>
<p>Criterion 3.1.3</p>	<p>PA Low</p>	<p>There are policies and procedures</p>	<p>An annual review of the IC</p>	<p>Ensure that annual review of</p>

<p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>		<p>to guide staff in implementation of the IC programme. The IC programme is implemented but annual review of the IC programme has not been completed for 2016.</p>	<p>programme has not been completed in 2016. Advised this was due to the receivership.</p>	<p>the IC programme occurs. 180 days</p>
<p>Criterion 2.2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made: (a) Only as a last resort to maintain the safety of consumers, service providers or others; (b) Following appropriate planning and preparation; (c) By the most appropriate health professional; (d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation.</p>	<p>PA Low</p>	<p>The use of restraint is only considered as a last resort after other interventions have been tried. The use of restraint is discussed by the restraint coordinator with the family/whānau and the GP. An assessment is completed and a consent for the use of restraint is documented. Not all risks associated with the use of restraint had been noted on the assessment and consent form and interventions had not been noted in the restraint care plan to manage the associated risks.</p>	<p>i) One of two residents using restraint did not have the risks associated with the use of the restraint documented in the assessment and consent process. ii) Two of two residents using restraint did not have interventions documented in the care plan to manage the risks associated with the use of the restraint.</p>	<p>i) Ensure that the risks associated with the use of restraint are documented in the assessment and consent process. ii) Ensure that interventions are documented in the care plan to manage the risks associated with the use of restraint. 90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.