

Tasman Rest Home and Dementia Care Limited

Introduction

This report records the results of a Surveillance 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:	Tasman Rest Home and Dementia Care Limited
Premises audited:	Tasman Rest Home & Dementia Care
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 7 March 2017 End date: 8 March 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:	51

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Dementia Care New Zealand Ltd (DCNZ) is the parent company of Tasman Rest Home and Dementia Care. The service provides rest home, hospital, dementia and psychogeriatric level care for up to 53 residents. On the day of audit there were 51 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The operation manager and clinical manager are supported by owners/directors, clinical director, quality systems manager, mental health nurse- education coordinator, project manager and national clinical manager. Residents and relatives interviewed commented positively on the high standard of care received at Tasman rest home and dementia care.

This unannounced audit identified an area for improvement around aspects of medicine management and registered nurse coverage.

The service has maintained a continuous improvement rating around staff education.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies are implemented to support residents' rights, communication and complaints management. Governance provide initial and ongoing support for families through meetings, newsletters, education seminars and support groups. Complaints and concerns have been managed appropriately and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The quality and risk management programme includes service philosophy, goals and a quality/business plan. Meetings are held to discuss quality and risk management processes. Residents/family meetings are held regularly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Falls prevention strategies are in place that includes the analysis of falls incidents. An education and training programme has been implemented with a current training plan in place for 2017. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate caregiver coverage for the effective delivery of care and support.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses the resident and develops the care plan documenting goals and outcomes with the resident (as appropriate) and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were reviewed at least six monthly. Resident files included the general practitioner, specialist and allied health notes.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three monthly.

A diversional therapist oversees the activity team and coordinates the activity programme for the rest home, hospital, dementia and psychogeriatric level of care residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents and families report satisfaction with the activities programme.

Resident food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritious snacks available 24 hours.

Safe and appropriate environment

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Tasman rest home and dementia care has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. No residents had enablers and two residents at psychogeriatric level of care had T-belt restraints.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems and policies and procedures are in place to minimise the risk of infection to residents, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	14	0	1	1	0	0
Criteria	1	38	0	1	1	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 1.1.13: Complaints Management</p> <p>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. Information about complaints is provided on admission. Interview with residents (one rest home and one hospital level of care) and relatives confirmed an understanding of the complaints process. There is an up to date on-line complaint register. There have been six complaints (verbal and written) within the last year complaints. All complaints reviewed had noted investigation, timeframes and corrective actions, including letters of acknowledgement. Management operate an open-door policy.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Relatives interviewed (one hospital, two psychogeriatric and one dementia level of care) stated they were welcomed on entry and given time and explanation about the levels of care provided and services and procedures. There is documented evidence of full and frank open disclosure regarding changes to their relative's health including incident/accidents, medication changes, GP visits and infections. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. . Relatives receive newsletters to keep them informed on facility matters, activities and topics of interest. The company hold family support groups for new families that is facilitated by an independent facilitator. The families also receive an invitation to orientation for families sessions. Families are offered to attend a three week "share the journey" course. A focus group meeting</p>

conducive to effective communication.		with family occurs annually. Interpreter services are available as required.
<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>Tasman rest home and dementia care provides care for up to 53 residents. The service is divided into smaller home-like care units (i) one 15 dual-purpose hospital/rest home beds, (ii) a 12-bed psychogeriatric (PG) care unit, (iii) two separate dementia care units with 13 beds in Ata care home and 12 beds in Rangī care home. The service is in two separate buildings with a walkway between them. The hospital and PG care units in one and the dementia care units in the other. On the day of audit, there were 51 residents. There were 11 hospital residents, three rest home residents, 24 residents across the two dementia care units and 12 residents in the psychogeriatric care unit. All residents were either under the ARC or the ARHSS contract.</p> <p>Tasman rest home and dementia care is one of nine facilities operated by Dementia Care NZ Limited (DCNZ). The nine aged care facilities throughout NZ provide rest home, hospital, medical, dementia and psychogeriatric level care. There is a corporate structure in place, which includes two directors and a governance team of managers. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. DCNZ has an overall 2016 – 2017 business/strategic plan based on “our services”, “our people”, “our environment” and the “sharing of experiences”. The business plan is regularly reviewed. The organisation has a philosophy of care, which includes a mission statement.</p> <p>Staff are supported with the provision of staff support services (interviewed). He visits the facility weekly and readily available to staff for debriefing sessions. Family support groups are held monthly with an independent facilitator</p> <p>The operations manager (non-clinical) of Tasman has been in the role since November 2015 and has previous experience in business management in tertiary services. The operations manager reports to the DCNZ operations management leader. He is supported by an organisational quality systems manager, education coordinator, project manager and owners/directors at head office. The clinical manager/registered nurse has been in aged care with DCNZ since 2009. The clinical manager has completed a post graduate certificate in the last year, attended a wound conference. The operations manager has attended at least eight hours of professional development including health and safety transition training and has almost completed the dementia unit standards. Both managers attend DCNZ seminars.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	FA	<p>There is a quality plan that includes quality goals and risk management plans for Tasman rest home and dementia care. The quality programme is managed by the operations manager and clinical manager. A quality systems manager for the organisation oversees the quality programme ensuring all aspects of quality management is implemented.</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Interviews with staff confirmed that there is discussion about quality data at various facility meetings including monthly quality improvement meetings and clinical meetings. There is documented evidence in meeting minutes of quality data, trends and analysis. Minutes and the staff monthly bulletin (displayed on the staff noticeboard) contain topical information and quality data. Organisational policies meet all current requirements and are reviewed at head office. Staff have access to the policy manuals.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. The operations manager completes environmental and non-clinical audits. The clinical manager undertakes all clinical audits. The internal audit programme continues to be implemented and all issues identified had corrective action plans and resolutions. The quality systems manager completes compliance site audits.</p> <p>Annual welfare guardian welfare surveys were completed in October 2016. Results were published in the family newsletter. Quality improvements raised and implemented were an increase in activities and ensuring clothing is labelled to prevent missing clothing items.</p> <p>The service has a health and safety committee which comprises of a health and safety officer, health and safety representative, BPSD (behavioural/psychological symptoms of dementia) advisor, manual handling advisor, restraint coordinator and care staff. All committee members have completed external health and safety education. Health and safety objectives for 2017 are known by staff and include a reduction of staff incidents to 20% from last year rates relating to resident's behaviour and from environment . The service has tertiary level of workplace safer management practice WSMP).</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. A falls map has recently been installed in the staff room to identify and monitor time and location of falls.</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</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. An on-line incident/accident register is maintained. The clinical manager investigates accidents and near misses and an analysis of incident trends occurs. There is a discussion of incidents/accidents at quality improvement and clinical meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents. Eleven incident forms reviewed (six falls psychogeriatric care, five falls dementia level of care) demonstrated that all appropriate clinical follow-up and investigation had occurred following incidents. Discussions with the operation manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. One section-31 incident notification form (sighted) was completed for a stage three pressure injury. The DHB had been notified of an absconding resident in August 2016. Appropriate monitoring had been put in place including a re-assessment of level of care.</p>

their family/whānau of choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Current practising certificates were sighted. Six staff files were reviewed (one clinical manager, two registered nurses, one home manager, one caregiver and one cook) and there was evidence that reference checks and/or police vetting were completed before employment. Annual staff appraisals were evident in all staff files reviewed. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation was evidenced and staff described the orientation programme.</p> <p>The in-service education programme for 2016 has been completed and the plan for 2017 is being implemented. The service identified that not all staff were able to attend education sessions and developed a workbook which is evaluated. The clinical manager and registered nurses are able to attend external training, including sessions provided by the local DHB and through the organisation. Eight hours of staff development or in-service education has been provided annually. There are 23 caregivers employed to work in the dementia units. Seventeen staff have completed the dementia unit standards. Three staff are progressing though the standards and three other staff have been employed less than three months. All RNs have completed first aid training. The organisation has an education coordinator who is a registered psychiatric nurse.</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>	PA Low	<p>Staffing rosters for each care unit were sighted and there are sufficient care staff on duty to meet the resident needs and resident safety on different shifts. There is a full-time plus on-call operation manager and clinical manager. Each care unit has a home manager (senior caregiver) on morning shift Monday to Sunday in addition to the care staff on the roster. Interviews with staff, residents and family members confirmed there are sufficient staff to meet the needs of residents. The service does not have a RNs on duty based in the hospital from 4.30pm-8.30am.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses who administer medications have been assessed for competency on an annual basis. Registered nurses complete syringe driver training. Education around safe medication administration has been</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>provided.</p> <p>Caregivers who have completed medication competency are able to check and administer medications. There were no standing orders on the day of audit. There were no residents self-medicating on the day of audit. There is an electronic medication documentation system, administration records and checking of medications on delivery. All medications are stored safely. The medication fridge is monitored daily. Eye drops are dated on opening. There were three expired medications at time of audit. There is a prescribing discrepancy for the time of administration for insulin.</p> <p>Twelve medication charts (two rest home, two hospital, four dementia care and four psychogeriatric care) were reviewed on the electronic medication system. All medication charts had photo identification and identified an allergy status. The GP had reviewed the medication charts three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Tasman Rest Home and Dementia Care are prepared and cooked on site by qualified cooks. The cooks are supported by afternoon kitchenhands. All staff have attended food safety and hygiene training. There is a four-weekly seasonal menu which had been reviewed by a dietitian. Meals are transported in food service trolleys and served from the kitchenette in rest home, hospital, dementia and psychogeriatric care kitchenettes. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements, diabetic, cultural and religious food preferences are met. Additional or modified foods are also provided by the service. Special diets include gluten free, vegetarian and low fat/low salt.</p> <p>Care staff were observed assisting residents with their meals and drinks in the hospital, rest home, dementia and psychogeriatric dining rooms. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. There are nutritious snacks available in the dementia and psychogeriatric units 24 hours.</p> <p>Fridge, freezer and end cooked temperatures are monitored daily. A kitchen cleaning schedule is in place and implemented.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all five current wounds (two ulcers, two facility acquired pressure injuries – stage-two and stage-three and one skin tear). There is a range of equipment</p>

<p>assessed needs and desired outcomes.</p>		<p>readily available to minimise pressure injury. Chronic wounds have been linked to the long-term care plans. There was evidence of wound nurse specialist involvement in the management of pressure injuries.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p> <p>A file review of a new admission with a potential risk of wandering identified that progress notes upon admission documents 'wandatrack' pendant in situ and AWOL chart commenced. A 24-hour MD care plan completed on admission with documented interventions for wandering and anxious behaviour.</p> <p>Monitoring occurs for weight, vital signs, blood glucose, pain, challenging behaviour, wounds, restraint, continence and two hourly positioning. Registered nurses review the monitoring charts and report identified concerns to the GP, nurse practitioner or nurse specialist.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service has two qualified diversional therapists (DT), and three trainees who are completing the DT qualification. The activity team provide a separate activity plan for each home (rest home, hospital, dementia and psychogeriatric) seven days per week. Activities are held in several locations within the facility. There is a variety of activities that meets the abilities of all residents. There is a knitting club and a 'men's club' and they have a tool box available and for those residents who wish to participate in the various garden projects. Volunteers involved in the activity programme include family, kindergarten children, pet therapy owners and community speakers. Entertainers attend the home regularly and there are regular outings and drives for all residents. Residents are supported to attend religious services of their preference. Special events and festivities are celebrated (staff decorate the facility) and families and staff are invited to attend. There are alternative activities (one-on-ones, books, word scratch, walks in the gardens and lazy-boy outings in the gardens) provided. The operations manager interviewed stated there is 'representational child therapy' (doll therapy) offered and approved by EPOA. One resident in the dementia care unit was observed resting comfortably in the lazy-boy chair holding the representational child.</p> <p>An activity assessment and plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed six monthly. Residents in the dementia and psychogeriatric care units have a 24-hour multidisciplinary care plan that covers resident activities and behaviours and de-escalation techniques over the 24-hour period.</p> <p>Residents and families can feed back on the activity programme via individual feedback, meetings and surveys. Residents and relatives interviewed stated they were very happy with the activities.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans reviewed were evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed at least six monthly or earlier for any health changes. The written evaluation documents the resident's progress against identified goals. The GP reviews the residents at least three monthly or earlier if required. Six monthly MDT meetings were evident with resident (as appropriate) and relative consultation. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service has a current building warrant of fitness that expires 5 July 2017.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme. The infection control nurse has been in the role six years and is supported by an infection control committee of six representatives across the organisation. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and analysed monthly for trends. Outcomes and actions are discussed at infection control meetings, quality improvement meetings and other meetings within the facility. A six-monthly review is completed. The infection control nurse is supported by the clinical manager and the organization national clinical manager and the clinical director. There has been one suspected outbreak (unconfirmed) which was communicated to the public health unit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents being restrained and one resident using an enabler (bedrails) during the audit. Enabler use was voluntary and risks were well assessed and documented in the care plan. A number of interventions had been implemented to reduce the need for the enabler but the resident continued to feel more comfortable with the enabler in place. Staff interviews and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage, challenging behaviours and de-escalation techniques including activities.</p>

minimised.		
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	There is an RN based in the 12-bed psychogeriatric unit 24/7 which is attached to the 15 dual purpose rest home/hospital. Additionally there is another registered nurse based in the hospital/rest home from 8.30 am until 4.30 pm. The psychogeriatric unit and rest home/hospital are in the same building in very close proximity.	There is one RN rostered over 24 hours a day and located in the PG wing. The contract with the local DHB states that the psychogeriatric unit and hospital unit can share a RN between 10.00 pm - 7.00 am only if the service is under 50 beds. There is not always a RN rostered in the hospital as well as the PG unit between 4.30 pm and 8.30am.	<p>Ensure RN covers meet the requirements of the ARC and ARHSS contracts.</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>	PA Moderate	All medications were stored safely. Medications are checked on delivery against the medication charts by a RN. Oral medications had been administered as prescribed. On day of audit a review of the controlled drug register, medication	(i) There were three expired medications (two in stock and one in the trolley) on the day of audit. (ii) There is a prescribing discrepancy for time of administration for insulin for one resident.	<p>(i) Ensure medications are checked for expiry dates. (ii) Ensure medication</p>

<p>review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>stock and insulin administration for one resident identified a shortfall in aspects of medicine management.</p>		<p>prescription instructions guide staff clearly as to the correct time of administration.</p> <p>30 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>There is a comprehensive education programme offered. Management identified that not all staff were able to attend mandatory training and developed a workbook.</p> <p>There has been a focus on attendance at identification and interventions for challenging behaviours.</p>	<p>The organisation has developed a user-friendly caregiver orientation workbook that includes a self-directed learning package that aligns with the first year of education requirements. The workbook includes the policy and comprehension questionnaire. A second-year workbook has been developed to cover the mandatory requirements of the two-yearly training calendar. Staff receive this workbook at their first annual appraisal. The education coordinator provides one day training on MAPA (management of actual and potential aggression) for all staff. The MAPA training is a new version which covers the previous NVCI (non-violent crisis intervention) training. The service has maintained continuous improvement around staff training. The effectiveness of the training is completed through the training evaluations and the reduction of behaviour incidents.</p>

End of the report.