

Stanthom Properties Limited - San Michele Home and Hospital

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Stanthom Properties Limited
Premises audited:	San Michele Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 August 2017 End date: 24 August 2017
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	24

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

San Michele Rest Home and Hospital can provide residential care for up to 29 residents. On the first day of audit there were 24 beds occupied. The facility is operated by Stanthom Properties Limited.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

Areas requiring improvement from this audit relate to a complaint register, governance, quality data analysis and corrective actions, meeting minutes, human resource management, care planning - including timeframes, assessments, interventions and evaluations, medication management, menu plan review, the physical environment, civil defence supplies and surveillance of infections.

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.	Yellow	Some standards applicable to this service partially attained and of low risk.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

The nurse manager is responsible for the management of complaints. There have been no investigations by the Health and Disability Commissioner since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Stanthom Properties Limited is the governing body and is responsible for the service provided. Quality and risk management plans were reviewed.

The facility is managed by a nurse manager who has been in this position for nine months. Prior to this role, the nurse manager was the clinical manager. The nurse manager is supported by a senior registered nurse and an administrator.

There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collected and collated. Management, staff and registered nurse meetings are held monthly. Minutes of meetings are available for staff to view.

Documentation, including policies and procedures have been reviewed and were current. There are policies and procedures on human resources management. In-service education is provided for staff at least monthly.

The hazard register evidenced review and updating of risks and the addition of new risks. The health and safety representative has completed an update on the Health and Safety at Work Act (2015) requirements.

A documented rationale for determining staffing levels and skill mix is in place to provide safe service delivery. The nurse manager is on call after hours. Care staff reported there is adequate staff available.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Single, double and triple room accommodation is provided. Adequate numbers of bathrooms and toilets are available. There are lounges, dining areas and alcoves. External areas for sitting and shading is provided.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems are audited for effectiveness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint minimisation and safe practice policies and procedures define enablers and restraints that complies with this standard. There are residents using restraint and enablers. Staff demonstrated an understanding of what constitutes safe enabler and restraint use.

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.		Some standards applicable to this service partially attained and of low risk.
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The infection prevention and control programme aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results discussed through all levels of the organisation. Follow-up action is taken as and when required.

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	35	0	7	8	0	0
Criteria	0	82	0	8	11	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And Support	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service

<p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The registered nurse provided examples of when they would involve and/or offer the support of the Advocacy Services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>The complaints policy meets the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there are complaints information and forms available in the facility.</p> <p>Complaint documentation showed three complaints have been received since the previous audit. Actions taken were documented and completed within the timeframes specified in the Code. There was no evidence of a complaints register.</p> <p>The nurse manager (NM) is responsible for complaints management and follow up. Documentation and interview of the NM evidenced the nurse manager attended a workshop in June 2017 that included the management of complaints. The NM stated they are booked to attend a workshop on complaint management provided by the local district health board (DHB) in November 2017. Staff demonstrated an understanding of the complaint process and what actions are required.</p> <p>The NM reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit. Documentation evidenced that the DHB became involved in a complaint made to the facility in April 2017. The complainant contacted the DHB following an unsatisfactory initial response back to the complainant by the facility. A replacement response was reviewed that documents the actions taken by the facility.</p> <p>The auditors were made aware while on site that a new complaint had been received by the local DHB and a request for the auditors to review a resident's file was made. The resident's file was reviewed and added to the overall number of residents' files reviewed. The findings from this file review is reflected in the continuum of service delivery section of this report.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in the main foyer areas of the facility together with information on advocacy services. How to make a complaint and feedback forms were found in the rest home and hospital lounge areas.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room, or share a room with another person/s with their consent. Privacy of residents whom reside in two of the facility bedrooms is compromised (please refer to criterion 1.4.2.4).</p> <p>Residents are encouraged to maintain their independence by participation in activities of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. There were no Māori residents who affiliate with their Maori culture at the time of audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, requiring interventions and special needs were included in care plans reviewed. The 2016 resident satisfaction survey confirmed that</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>individual needs were being met.</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>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, the renal community nurse, podiatrist, psychogeriatrician and mental health services for older persons, and education of staff. One of six general practitioners (GP's) supporting the facility confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents being able to speak English, staff able to provide interpretation as and when needed, and the use of family members.</p>
<p>Standard 1.2.1: Governance</p>	<p>PA Low</p>	<p>There is a mission statement and a list of organisational objectives. It was unclear as to when the</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>objectives were developed as there was no evidence of a timeframe for review, or whether they have been reviewed. There was not a document available, such as a business plan, that includes the scope, values and direction of the organisation. Systems are in place for monitoring the service through on-site monthly meetings with the owner. Minutes of meetings confirmed this.</p> <p>San Michele Rest Home and Hospital is managed by a nurse manager (NM) who has been in this role since November 2016. The NM attended a manager's leadership course in July 2017 and in-service education at the facility. Prior to accepting this position, when the business manager resigned, the NM was in the position of clinical manager for 13 years. The nurse manager is supported by the senior RN and a newly appointed administrator. The nurse manager reported they are still learning the role the resigned business manager was responsible for and the employment of an administrator has helped with this.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>San Michele is certified to provide hospital and rest home level care. On the first day of this audit there were 15 hospital level residents, seven rest home level residents and two people convalescing short-term before going home.</p> <p>The service has contracts with the DHB to provide Aged Related Residential Care, 'Residential Respite Services' and post-acute convalescent care (PACC). The service also has a contract with the Ministry of Health titled 'Outcome Agreement' for residents under the age of 65 years.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the nurse manager, the senior RN deputises. The NM and senior RN confirmed their responsibility and authority for these roles.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>PA Moderate</p>	<p>A quality improvement programme includes flow charts to guide staff and a risk management plan includes a risk matrix. Registered nurse and staff meetings are held monthly. Meeting minutes reviewed were not comprehensive and lacked detail. Although staff stated they receive results of quality improvement data and discuss trends, there was insufficient detail evidenced in the meeting minutes to support this.</p> <p>The family satisfaction survey for 2017 has not yet been collated, but indicated residents and</p>

<p>principles.</p>		<p>family are satisfied with the services provided. The satisfaction survey undertaken for 2016 was not able to be located.</p> <p>An internal audit programme is in place and completed audits for 2016 and 2017 were reviewed along with clinical indicators and quality improvement data. Review of the quality improvement data evidenced data is being collected and collated, however, any analysis and trending of data is either inconsistent or consists of numbers only of clinical indicators. Corrective actions were developed and implemented for maintenance, audits and incident/accidents. These had not been reviewed to evidence effectiveness. Meeting minutes do not evidence corrective actions, who is responsible for the action and time frames for the action to be completed.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies/procedures have either been reviewed or are currently being reviewed. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery.</p> <p>Actual and potential risks are identified and documented in the hazard register, including risks associated with human resources management, legislative compliance, contractual risks and clinical risk and showed the actions put in place to minimise or eliminate risks. Newly found hazards are communicated to staff and residents/family as appropriate. The health and safety representative is responsible for hazards. Staff confirmed they understood and implemented documented hazard identification processes.</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>The nurse manager is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police attending the facility, sentinel events, infectious disease outbreaks and changes in key management roles. The NM advised there have been no deaths referred to the coroner or essential notifications to Ministry of Health (MoH) and district health board (DHB) since the last audit. The NM stated HealthCERT has been advised of the change in the manager.</p> <p>Staff interviewed and review of documentation evidenced staff document adverse, unplanned or untoward events on an accident/incident form which is signed off by the NM. Completed incident/accidents forms are used to make improvements. (See criterion 1.2.3.8).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>PA Moderate</p>	<p>Policies and procedures relating to human resources management are in place. Staff files include employment agreements, completed orientation (apart from the nurse manager), competency assessments, performance appraisals and education records. There was no evidence on staff</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>files of reference checks and police vetting. Position descriptions for the restraint coordinator and infection control coordinator were not on the staff member's files and an agreement between the nursing bureau and the facility was not evidenced until the facility requested a replacement during the audit.</p> <p>The education programme is the responsibility of a senior RN. There was evidence of in-service education provided for staff and documentation showed this is provided several ways including online learning in pairs, monthly education sessions and other sessions externally. The senior RN educator reported there is good attendance at education sessions. Individual records of education including competencies are held on staff files. Staff have received several sessions on manual handling by an external educator and staff demonstrated a clear understanding of hoist use. Attendance records are maintained and evidenced attendance at the sessions. The senior RN and the nurse manager are interRAI trained. Competencies are current. The cook rostered on the day of audit has not undertaken any relevant food handling training within the last 10 years.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to two months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided. The nurse manager's file had no evidence of an orientation to their current position. The nurse manager confirmed this.</p> <p>Staff performance appraisals were current. Annual practising certificates are current for RNs and the EN. Copies of practising certificates for GPs and pharmacists were on file, however these had expired.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</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>	<p>FA</p>	<p>There is a documented rationale and process in place to determine the services provider levels and skill mixes to provide a safe service.</p> <p>Rosters were reviewed and evidenced sufficient cover to provide safe services. Registered nurse (RN) cover is provided 24 hours a day. Two of the seven permanent RNs are currently unavailable and two bureau RNs are rostered on for two-night shifts per week. (See link to 1.3.12.3). The minimum number of staff is on the night shift and consists of one RN and one caregiver. The nurse manager is on call after hours.</p> <p>Staff and families interviewed reported there are adequate staff available. Resident and family</p>

		interviews confirmed that services meet their needs.
<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>All necessary demographic, personal, clinical and health information was completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (DSL) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from DSL and the GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed appropriate documentation and communication. Family of the resident reported being kept well informed during the transfer of their relative.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who are employed by the facility and administer medicines are competent to perform the function they manage; however, the facility is unable to evidence medication competency of bureau staff. (See criterion 1.2.7.5) The NM reported a bureau RN mistakenly tried to administer medicine to a resident who self-administers their own medication.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart. The registered nurse interviewed stated that not all standing orders are signed by all the supporting GPs, stating that the registered staff are aware of this.</p> <p>There is one resident who self-administered medications at the time of audit. Appropriate processes are not in place and evidenced to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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 is provided on site by three cooks, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns The menu has not been reviewed by a qualified dietitian within the last three years. At the time of audit, the dietitian was booked to visit the facility in October 2017.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high</p>

		<p>risk items, are monitored appropriately and recorded as part of the plan. The cook rostered on the day of audit has not undertaken any relevant food handling training within the last 10 years (see criterion 1.2.7.5).</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Families and residents interviewed stated that they were happy with meals provided and the service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, DSL is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to DSL is made and a new placement found, in consultation with the resident and whānau/family. Examples, if this situation was to occur, were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Moderate	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information; however, not all residents had updated supporting assessments completed. This included three residents with weight loss, a resident with an indwelling catheter with variable outputs, challenging behaviours/wandering and who fell regularly. All residents have current interRAI assessments completed by one of two trained interRAI assessors on site. Residents and families interviewed confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and</p>	PA Moderate	<p>Care plans reviewed did not always reflect the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were not always reflected in care plans reviewed.</p>

<p>promote continuity of service delivery.</p>		<p>Any change in care was verbally passed onto relevant staff however this information was not always documented and/or evidenced in progress notes or assessments (refer to criterion 1.3.8.2). Service integration of progress notes, activities notes, medical and allied health professionals' notations did not always evidence informative and relevant information. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. One of six GP's interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. Care staff confirmed that care was provided as outlined in the documentation; however, the 'daily activities of living tick sheet' was not completed to reflect the care plans. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapist.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Resident meetings are no longer held. Families/whānau are involved in evaluating and improving the programme through regular individual and group discussions. Family and residents interviewed confirmed they find the programme interactive.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>The six-monthly interRAI reassessment is utilised as a formal care plan evaluation, or if residents' needs change significantly. Where progress is different from expected, the service responds by initiating changes to the plan of care, however short-term care plans are not reviewed and</p>

		<p>progress evaluated as clinically indicated for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. The resident and the family/whānau were kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current.</p> <p>There was protective clothing and equipment in the sluice room and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a good understanding of processes relating to the management of waste and hazardous substances.</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>	PA Moderate	<p>A current building warrant of fitness is displayed that expires 17 June 2018. The building, both internally and externally is in need of maintenance. Residents and family confirmed they can move freely around the facility and that the accommodation meets their or their relative's needs. It was noted that family commented in the satisfaction survey for 2017 that the wall paper is 'looking dated' and the building starting to look 'tired'.</p> <p>Two double rooms have curtains installed in a way that do not provide privacy to both residents. The vinyl on the floor in the laundry is lifting. Several paper towel dispenses are rusty. One of the wash hand basins has a damaged seal, is mouldy and water is seeping through. The shower wall in hospital B side is damaged and water is leaking through. There is dry rot in the exterior of the building and the exterior is in need of cleaning.</p>

		<p>Maintenance is undertaken by a maintenance person and there is a proactive and reactive maintenance programme. The testing and tagging of electrical equipment and calibration of bio-medical equipment is current.</p> <p>There are external areas available and are appropriate to the resident groups and setting. Residents are protected from risks associated with being outside. The building is on different levels and ramps with hand rails are provided.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of bathrooms and toilets throughout the facility. All bedrooms have a wash hand basin. Residents and families reported that there are sufficient toilets and they are easy to access.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are three double bedrooms and four three bedded bedrooms with the rest offering single accommodation. Adequate personal space is provided for residents and staff to move around within the bedrooms safely. Residents and families stated their or their relative's accommodation is adequate. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids as needed.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has lounge/dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>The dining areas have adequate space for residents. Residents can choose to have their meals in their rooms.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is washed on site. Residents and family reported the laundry is managed well and residents' clothes are returned in a timely manner.</p> <p>Cleaning and laundry staff have received appropriate education. Chemicals are stored securely. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>There is a fire evacuation scheme that was approved 27 July 1999. An evacuation policy on emergency and security situations covers the service groups at the facility. A fire drill takes place six-monthly; documentation confirmed this. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. Required fire equipment was sighted and all equipment has been checked within required timeframes.</p> <p>There is always at least one staff member on duty with a current first aid certificate.</p> <p>A civil defence plan is in place. Adequate supplies of food, water, blankets, cell phones and gas BBQ were sighted in the event of a civil defence emergency. Battery powered emergency lighting is provided. The contents of the civil defence kit is not sufficient and does not meet requirements and a list of required contents was not evident. Documentation evidenced the last check of the contents was completed in 2014.</p> <p>There are call bells in all resident areas and these were observed to be answered in a timely manner.</p> <p>Contractors must sign in and out of the facility. The external doors locked at dusk and there are external sensor lights.</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>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by gas and electric heaters. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable.</p> <p>The NM stated the area where staff smoke has been reviewed, however, there are no other areas suitable. The NM stated the number of staff who smoke has reduced to three and they have been advised they are not to smoke in the designated area all at the same time. The NM advised this has significantly reduced the amount of smoke generated and smoke is no longer</p>

		drifting into the facility. Observations confirmed this.
<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>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external sources as required. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse (not available at the time of audit) is the designated IPC coordinator. Her role and responsibilities are not evidenced and defined in a job description (refer to criterion 1.2.7.3). The senior registered nurse confirms that infection control matters, including surveillance results and prevention outcomes, are discussed at staff meetings which include representatives from food services and household management; however, this is not evidenced in minutes of meetings (refer to criterion 3.5.7).</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has knowledge of infection control, and has been in this role for two years; however, no infection control education is evidenced in training records sighted. Support and information is accessed from the senior registered nurse who completes training for staff, the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator was not available at time of audit however the registered nurse confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in February 2017 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the</p>

and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		facility. Staff interviewed verified knowledge of infection control policies and practices.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	PA Low	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. There is a senior registered nurse with training in infection control who supports the IPC nurse however the IPC nurse is unable to provide any evidence of formal training in infection control.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	PA Low	<p>Surveillance includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC coordinator documents all reported infections. Staff interviewed stated that new infections and any required management plan are verbally discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated; however information gathered is not analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are not evidenced as shared with staff via regular staff meetings. Graphs are not produced that identify trends for the current year, and comparisons against previous years. Data is not benchmarked externally.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes enablers and meets the requirements of the standard. There are currently nine residents using restraint and one resident using an enabler. Enabler use is voluntary and the least restrictive option. The nurse manager is the restraint coordinator and demonstrated good knowledge relating to restraint minimisation. Staff were knowledgeable about restraints and enablers. The nurse manager reported the service actively tries to minimise restraint use through assessment, high/low beds and changing a resident's room if needed, to be closer to where staff are situated.</p>

<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	<p>The restraint policy and procedure meets the requirements of the standard. Responsibilities of the restraint coordinator and approval group are outlined in the policy. (See link criterion 1.2.7.3) Restraints to be used for the residents are approved by the restraint approval group prior to commencing the restraint. The GP completes a three-monthly review of the restraints in use.</p> <p>Restraint use is discussed in the staff meetings. Staff confirmed their knowledge of the restraint processes.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The assessment forms meet the requirements of the standard. Completed assessment forms prior to commencing any restraint were in the file of the residents using restraint. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. The resident's care plan documented desired outcomes. Staff demonstrated good knowledge in maintaining culturally safe practice when completing assessments for restraint use.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Safe use of restraint is promoted. The residents' care plans evidenced restraint use and the risks associated with restraint. There is a current and updated restraint register. Staff receive induction and orientation as well as on-going education relating to restraint processes. Evidence of ongoing education regarding restraint and challenging behaviours was evident. Restraint competency testing of staff is included in their education process.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The evaluation of restraint is completed by the GP at three monthly intervals. The restraint coordinator completes a restraint evaluation six monthly that meets the requirements of the standard. The residents' file evidenced evaluation of restraint was completed three and six monthly. Staff confirmed their feedback is obtained by the restraint coordinator when evaluating the restraint in use.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p>	FA	<p>Monitoring and quality review of restraint use was evidenced. Restraint is included in the staff monthly meetings. Audits relating to restraint use have been completed and include review of</p>

<p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>residents' clinical records. The nurse manager reported the restraints used are bed rails only and these are mostly in situ at night. The use of high/low beds, sensor mats and changing rooms for residents if needed so that they are closer to foot traffic, has helped to reduce the use of restraint.</p>
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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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	There was no evidence of a complaints register. The nurse manager reported they didn't know if there had ever been one kept in the complaints folder. The complaints folder held all complaints received and met Right 10 of the Code.	A complaints register was not evidenced.	<p>Provide evidence that a complaints register has been developed implemented and maintained.</p> <p>30 days</p>
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	A mission statement and a one-page list of organisational objectives was sighted within the policy and procedure file. It was unclear as to when the objectives were developed and what the timeframe is for review. There was not a document available, such as a business plan, that included the scope, values, purpose and direction of the organisation. A filing cabinet with a section titled 'business plan was sighted; however, it was empty and a business plan was not located. There are systems in place for monitoring the service through on-site monthly meetings with the owner. Minutes of meetings confirmed this and	Although a mission statement and organisational objectives were evidenced, it was not clear as to when the objectives were developed and if they had been reviewed. There was evidence that a business plan had	Provide evidence, such as a business plan, that the purpose, values, scope, direction and goals of the organisation are clearly identified and reviewed on a regular

		included, but was not limited to, occupancy, human resources, health and safety, building maintenance and equipment.	existed, however, the area in the filing cabinet was empty and the nurse manager could not recall having seen a business plan.	basis. 30 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Quality data is being collected and collated. Analysis of data to identify trends is either inconsistent, not comprehensive or consists of numbers only of clinical indicators. Staff interviewed stated they do discuss analysis and trends resulting from quality data and what to do about it at meetings. Staff and RN meeting minutes evidenced they are brief and do not document reporting of analysis and trends. The satisfaction survey for 2017 has yet to be collated. There was no evidence of analysis from the 2016 satisfaction survey and the surveys and results were not located.	Quality data is not consistently analysed to identify trends. Although staff reported they discuss trends and actions at the staff meetings, there was little evidence to support this in the minutes of meetings.	Provide evidence that quality data is consistently and comprehensively analysed to identify trends and the results provided to staff are documented in the staff and RN meeting minutes. 60 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	There was evidence of corrective actions plans developed and implemented for maintenance, audits and incident/accidents, however these had not been reviewed to evidence effectiveness. Meeting minutes do not evidence corrective actions, who is responsible for the action and time frames for the action to be completed. The 2016 satisfaction survey and any corrective actions were not available. The 2017 sent out to families in July is yet to be collated.	Corrective actions, who is responsible and timeframes for the action to be completed is not evidenced in the staff and RN meeting minutes. The 2016 satisfaction survey was unable to be located including any corrective actions. Where action plans have been developed and implemented, review of the action plan for effectiveness is not	Provide evidence that corrective actions are developed, implemented and reviewed where deficits are identified. 60 days

			evidenced.	
<p>Criterion 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>	PA Low	<p>Practising certificates for the registered nurses and the enrolled nurse were sighted and are showed they are all current. Although there were copies of practising certificates for the GPs and pharmacists, on file, they had expired in 2015.</p>	<p>Copies of practising certificates for allied health professional and the GP were not current.</p>	<p>Provide evidence that copies of practising certificates for allied health professional and the GP are current.</p> <p>30 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Moderate	<p>Human resources -employment of staff policy includes referencing checking. Staff files evidenced employment agreements, position descriptions, completed orientations for staff, competency assessments, performance appraisals and education records. Staff files reviewed, both recent and staff employed over the past several years had no reference checks and police vetting. The nurse manager reported reference checks have been carried out for new staff, however documentation was not evidenced on staff files. The nurse manager also reported that police vetting has never been undertaken for new staff. The nurse manager's file had no evidence of a position description for the restraint coordinator and the RN's file had no position description for infection control coordinator. Although the nurse manager and administrator stated they had seen an agreement between the nursing bureau and the facility for the RNs currently being contracted, it was not able to be found. A replacement was requested and received from the bureau during the audit.</p>	<p>There was no evidence in staff files of reference checks and police vetting. The staff who are the coordinators for restraint and infection control have no evidence of position descriptions on file. An agreement for the contracting of RNs from a local bureau was not evidenced until a replacement was requested during the audit.</p>	<p>Provide evidence that: (i) reference checks and police vetting is completed for all potential employees and documentation held on file; (ii) the nurse manager has position descriptions on file for coordinator of restraint and infection control; (iii) the agreement between the bureau and the facility is available and kept on file.</p> <p>60 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an</p>	PA Low	<p>All staff files reviewed had evidence of an orientation on file that covered all the essential components required. There was no evidence on the nurse manager's file that an orientation has been completed for the role of nurse manager. The nurse</p>	<p>The nurse manager has not received an orientation to the new position of nurse</p>	<p>Provide evidence that an orientation has been completed for the nurse manager</p>

<p>orientation/induction programme that covers the essential components of the service provided.</p>		<p>manager reported that although there was a four week overlap before the business manager left, an orientation to the combined position of nurse manager from clinical manager did not occur. The nurse manager reported they have had to learn the responsibilities that were carried out by the resigned business manager. The nurse manager reported the appointment of an administrator has helped to take some over some of the responsibilities.</p>	<p>manager and there is no evidence on file of one having been completed.</p>	<p>and documentation relating to this is kept on the nurse manager's file.</p> <p>30 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>Education programmes for the last six months of 2016 and this year were reviewed. There was evidence of in-service education provided for staff and documentation showed this is provided several ways including online learning in pairs, monthly education sessions and other sessions externally. The senior RN educator reported there is good attendance at education sessions. Individual records of education and restraint and medication competencies are held on staff files. The facility was not able to provide evidence to show that contracted bureau staff are medication competent. The cook rostered on the day of audit has not undertaken any relevant food handling training within the last 10 years.</p>	<p>Medication competency assessments for bureau staff were not evidenced. There was no evidence on the cook's file of a certificate relating to food handling.</p>	<p>Provide evidence that (i) bureau staff have current medication competencies and (ii) the cook has completed training in food handling.</p> <p>60 days</p>
<p>Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>There is one resident who self-administered medications at the time of audit. The resident when interviewed was able to show competency with self-medication with his inhalers. The resident did not have his medications in a locked box in his room (as verbally offered by the facility), as he rarely left his room and due to his extensive medical history and reduced mobility 'felt safer' to have his medications beside him on his bed. A signed consent by the GP was evidenced; however, no assessment and/or discussion was evident to show competency was discussed with the resident.</p>	<p>No evidence of an assessment was provided to show that the resident was competent to self-administer medication.</p>	<p>Ensure that residents are assessed as safe to self-administer medication.</p> <p>30 days</p>

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Low</p>	<p>The cook interviewed was able to show evidence of residents likes and dislikes and alternative food options for residents. The residents and family interviewed stated that they were happy with the food provided. On the day of audit, the facility booked the dietitian to review the menus in October 2017. The facility menu was last reviewed by the dietitian 12 August 2014.</p>	<p>The food menu has not been reviewed by a dietitian within the last three years.</p>	<p>Ensure that the menus are reviewed by the dietitian to meet recognised nutritional guidelines.</p> <p>180 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>All residents admitted to the facility are seen by their GP with 48 hours of admission and then routinely every three months thereafter. Residents and families interviewed stated that they were happy with the care provided. Three of the six files reviewed documented significant changes and deterioration in resident's health however there was no evidence to show prescribed intervention from the GP and/or relevant allied staff.</p>	<p>Not all residents with changes in health status are seen by their GP and/or relevant allied staff.</p>	<p>Ensure that when there is a change in status that residents are seen by their GP and/or allied health person and this is documented along with any required/prescribed interventions.</p> <p>30 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Moderate</p>	<p>All residents had an initial nutritional profile and falls assessment at the time of admission. The cook confirmed that staff discussed changes of diet and supplements required for individual residents, and progress notes recorded changes in appetite. The registered nurse interviewed stated that at three monthly reviews the GP is provided with monthly weights. Residents and families confirmed they were happy with meals and support provided at meal times. Three of six files reviewed showed weight loss with no evidence of further assessments. Two of six residents' incident forms evidenced frequent falls, one resident had an indwelling catheter with variable urine output; however, no evidence was provided to show ongoing</p>	<p>Not all residents have ongoing assessments to support changes in their health status and to support service delivery planning</p>	<p>Ensure that all residents have assessments to highlight appropriate service delivery required and to serve as the basis for service delivery planning</p> <p>30 days</p>

		assessments thus care plans were not always accurate and did not always reflect changes in requirements.		
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>Staff interviewed were able to discuss the required needs for all residents. Residents and families interviewed stated that they were happy with the care received. The registered nurse interviewed stated that the care interventions are provided however not all care plans reflected the care that the staff stated they were providing or that the residents required. Three resident's files evidenced information in care plans that contradicted the actual care that the residents required for example mobility, nutrition, support with personal care and hygiene needs.</p>	<p>Not all care plans identified specific and accurate interventions related to the resident</p>	<p>Ensure that all delivery plans describe accurately the required support and/or intervention</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Staff interviewed discussed the personal needs required for all residents. Residents and families interviewed stated that they were happy with the care received. The registered nurse interviewed stated that the care interventions are provided; however, this is not reflected in the 'daily activities of life tick sheet' completed by care staff. Five of the six residents' files reviewed highlighted the specific needs of each resident's oral hygiene. The daily tick sheet did not evidence this care as being provided and occurring every day and/or twice daily as highlighted in the long-term care plans.</p>	<p>Not all documentation reflected daily care provided to residents by care staff.</p>	<p>Ensure that the care provided to residents is reflected in the documentation completed daily.</p> <p>30 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or</p>	<p>PA</p> <p>Moderate</p>	<p>The staff interviewed knew the residents well and were able to verbally verify the current status of the residents they were caring for. A separate short-term care plan has been implemented to support pressure injury care and showed evidence of evaluation; however, there was no written evaluations and closing of short term care plans evidenced for one resident who had an indwelling catheter with variable urine output, presented with challenging behaviours/wandering and fell regularly, and two of six residents who had frequent falls with</p>	<p>Short term care plans did not show evidence of evaluations.</p>	<p>Ensure that all short-term care plans are evaluated.</p> <p>30 days</p>

intervention, and progress towards meeting the desired outcome.		associated injuries and three residents whom had documented evidence of weight loss. InterRAI assessments do not always reflect short term care plan evaluations and outcomes.		
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Moderate	<p>Mobility aids are stored safely and passageways are wide enough for residents to pass safely. The building has hand rails situated throughout, including external ramps.</p> <p>Rooms nine and 11 have curtains installed in a way that do not provide privacy for the residents nearest the door. The curtains are installed between the two bed spaces, but do not continue around the bed space of the resident nearest the door which means the resident nearest the door is not provided privacy when the other resident or visitors enter the room. The vinyl on the floor in the laundry is lifting showing the concrete underneath. Several paper towel dispenses are rusty including those in the sluice and next to the wash hand basin in the passageway. The wash hand basin in the passage next to the sluice has damaged seal, is mouldy and water is seeping through to the wall. There is dry rot in weather boards on exterior of the building and the exterior in general is dirty.</p>	<p>(i) Privacy for residents nearest the door in room nine and 11 is compromised. (ii) Flooring in the laundry has lifted showing the concrete. (iii) Paper towel dispenses are rusty. (iv) The seal around the wash hand basin in the passage way is damaged and mouldy with water is leaking through. (v) The shower wall in hospital B side is damaged and water is leaking through. (vi) The exterior of the building has areas of dry rot and the building is dirty.</p>	<p>Provide evidence that: (i) the residents nearest the door in rooms nine and eleven are provided with privacy; (ii) the vinyl in the laundry has been replaced or repaired; (iii) the paper towel dispensers that are rusty have been replaced; (iv) the seal around the wash hand wash is replaced; (v) the weather boards that have dry rot are replaced and exterior of the building is cleaned.</p> <p>90 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified</p>	PA Moderate	<p>Staff have received education in emergency and security management and staff interviews and documentation confirmed this. Fire evacuation drills are completed six-monthly. A civil defence plan is in place. Emergency lighting is battery powered. Adequate supplies of food, water, blankets, cell phones and gas BBQ were sighted in the event of a civil defence emergency. Battery powered emergency lighting is provided. The civil defence kit lacks essential supplies and a list of required</p>	<p>The civil defence kit has not been checked since 2014, a list of required items was not available and the contents doesn't have all essential supplies as per civil</p>	<p>Provide evidence that the civil defence kit has the required items in the event of an emergency, a list of contents is available and is checked on a regular</p>

emergency and security situations. This shall include fire safety and emergency procedures.		contents was not evident. A note book entry evidenced the last check of the contents was completed in 2014.	defence guidelines.	basis. 30 days
Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.	PA Low	The facility is supported by external specialised support as and when required. There is a senior registered nurse with training in infection control who supports the IPC nurse however the IPC nurse is unable to provide any evidence of formal training in infection control.	The registered nurse with the title of infection control nurse has no evidence of having completed any formal training in infection prevention and control.	Ensure that the registered nurse who holds the title of infection control nurse, has formal training in infection prevention and control. 180 days
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	PA Low	InterRAI and long-term care plans identify interventions for residents who have frequent and/or are of a high risk of infection. Infections are highlighted on the short-term care plan (though no intervention or signature identifying closure of infection is noted); however, information evidenced in long term care plans. Families interviewed are happy with the care provided for their relative. Staff interviewed were able to discuss interventions to reduce and minimise the risk of infections and were able to identify residents who are high risk. Staff identified that residents unwell are discussed at handover. Surveillance reports and minutes of staff meetings did not evidence discussion of monthly infection surveillance and/or reduction and prevention outcomes.	Infection surveillance date is not evidenced and/or reported and discussed at staff meetings (refer to criterion 1.2.3.8).	Ensure that results of monthly surveillance and reduction and prevention of infections and outcomes are evidenced in surveillance reports, discussion and minutes of staff meetings. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.