

Lara Lodge 2017 Limited - Lara Lodge

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 HealthShare Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Lara Lodge 2017 Limited
Premises audited:	Lara Lodge
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 September 2017 End date: 7 September 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:	16

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

Lara Lodge provides rest home level care for up to 27 residents. This unannounced surveillance audit was conducted against the Health and Disability Service Standards and aspects of the service contract with the district health board (DHB).

The audit process included the review of relevant policies and procedures; review of resident and staff files; observations and interviews with residents; family; management; staff; a medical officer and another health professional.

Most requirements identified at the previous audit have been met. These include improvements in relation to human resource management (to employment agreements and criminal vetting); assessment and care planning (review of assessments, completion of initial assessments, signing of consent forms, initial medical assessments completed in a timely manner and copies of district nursing plans now in resident records); the management of residents with pressure injuries; medicines management (including review of medications by a medical officer, documentation and competency of staff); cleaning of the kitchen and monitoring of fridge and freezer temperatures and the calibration of medical equipment and hoists.

Requirements are still required to performance appraisals; review of care plans including updating of care plans as changes occur; ongoing development of the activities programme.

A further improvement identified at this audit is required to document evidence of discussion of elements of the quality programme.

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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Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents demonstrated they are provided with adequate information and that communication is open.

Resident meetings provide feedback and confirm regular communication and involvement. Communication records are maintained. If required, the service will access interpreters from the District Health Board. Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. The complaints register is current.

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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The facility manager provides oversight and management of the service. The clinical operations manager provides clinical oversight of service delivery. There are adequate numbers of staff on duty at all times with the clinical operations manager providing an on-call service.

There is a documented quality and risk and management system which includes a range of policies, procedures and associated forms. There is a system in place for recording adverse events and there is some documentation of discussion of quality data and trends.

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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Service provision is coordinated to promote continuity of service delivery. The residents and family interviewed confirm their input into care planning and access to a range of life experiences and choices. A sample of resident clinical files confirmed service delivery meets residents' needs.

There is a planned activities programme with residents also accessing community activities.

The medicine management system is described in policy and implemented as per policy. Medication is securely stored.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Residents' dietary needs are identified on admission and reviewed on a regular basis. Residents confirm that adequate fluids and food is provided and snacks are available between meals.

Safe and appropriate environment

<p>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.</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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All building and plant comply with legislation with a current building warrant of fitness in place. A maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Outdoor areas are available and accessible to residents.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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Restraint policies and procedures include definitions of restraint and enablers which are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. There is a documented surveillance programme with a low number of infections documented in the past year.

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	10	0	3	5	0	0
Criteria	0	34	0	6	5	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

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 operates a consumer complaints process that references Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The service has an up-to-date complaint register which identifies the date of the complaint and documentation of resolution.</p> <p>There have not been any complaints since the new ownership and the register indicates that the last complaint was documented in 2015. The facility manager and clinical operations manager confirm that there are no external complaints.</p> <p>Residents and family interviewed confirm they have had the complaints procedure explained to them and they could describe the process for making a a complaint if required. Staff were aware of their responsibility to record and report any consumer complaints they may receive. The resident meeting minutes document that residents have been informed of the complaints process at each meeting. They are also informed at each meeting of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is provided.</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Family members are documented as being informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in accident/incident forms reviewed. While some incident forms do not document that family have been informed, it was noted that these residents were able to communicate and incidents were low level and witnessed. Two residents were asked if family should have been notified with recent incidents and both stated that they did not wish for family to be notified. The previous improvement identified at the provisional audit has been met.</p> <p>Family contact is recorded in residents' records including documentation in the progress notes. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to participate in the entry process for their family member and in ongoing care options.</p> <p>Interpreting services are available from the District Health Board. All residents have English as their first language. The information pack is available in large print and this can be read to residents.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Lara Lodge provides rest home level care for up to 27 residents. On the days of audit there were 16 resident requiring rest home level care.</p> <p>The service was purchased on 31 March 2017. The philosophy of the service is documented and reflects quality of care for aged care. There is a business risk assessment and management plan in place which includes the quality plan. It contains the purpose, values, scope, and direction. The goals of the organisation are identified and the plan includes objectives and who is responsible. The plan has been briefly reviewed by the clinical operations manager with a further review in progress.</p> <p>There are two owners. They have owned and managed services for people with disability for over 10 years, a sound knowledge of health services and are able to apply this to the aged care sector.</p> <p>The clinical operations manager was appointed to the role in September 2016 and they are a registered nurse. The clinical operations manager has extensive experience in the District Health Board including work in oncology services. The clinical operations manager maintains their eight hours professional development per annum and the facility manager continues to have over eight hours training in clinical and management. Both can describe their roles related to their areas of expertise.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and</p>	<p>PA Moderate</p>	<p>The business operates a quality risk and management system which includes a range of policies, procedures and associated forms. The quality and risk management system is documented. The 2016 quality and risk management plan is yet to be reviewed and the improvement required at the previous audit remains.</p> <p>There are policies and procedures in place that are aligned with current good practice and service delivery,</p>

<p>risk management system that reflects continuous quality improvement principles.</p>		<p>meet the requirements of legislation, and are reviewed at regular intervals. The policies include reference to interRAI assessments and care planning and the Health and Safety at Work Act. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures are accessible by staff.</p> <p>The quality and risk management system is linked with the health and safety, complaints management and infection prevention and control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of service delivery. There is evidence that corrective action plans are documented when required and resolution of issues documented. The previous improvement required has been met.</p> <p>Data is collated and the intention is to discuss these at the quality meetings. The clinical manager states that the first meeting has been held. Staff meetings are held monthly with some evidence of discussion of data. The improvement required at the previous audit remains. The clinical operations manager and the facility manager meeting daily to discuss any issues and review clinical care and management issues.</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted included the identified risks, how these are monitored, if the risk is a significant risk and if the implemented actions can isolate, eliminate or minimise the risk. The hazard register is maintained with this updated as risks are identified.</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 service has a documented and known processes for reporting, recording, investigating and reviewing adverse events. Staff can describe the process for reporting incidents. The clinical operations manager and the facility manager can describe the process for reviewing and managing any incidents.</p> <p>A review of incident/accident records and analysis confirms that all events are reported, recorded and reviewed by the clinical operations manager after documentation with a review of the incidents occurring monthly.</p> <p>The staff are aware of the need to complete vital signs if there is an unwitnessed fall or head injury. A monthly record is retained of all incidents with these tabled at the staff meetings and quality meeting recently held (refer 1.2.3).</p> <p>The clinical operations manager understands the responsibilities for essential notification to the relevant authorities. The service has not had to report any adverse events to external agencies.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Human resources policies describe good employment practices that meet the requirements of legislation. A sample of employee records confirmed that each employee has an employment agreement in place signed by the employer and the employee; an application form and letter of offer. A copy of completed training is kept on file.</p> <p>Performance appraisals are not current. Referee checks and evidence of criminal vetting are not able to be sighted. Orientation records have not been retained in the past and a new staff member does not have documentation of completion of orientation. The improvement required at the previous audit remains</p> <p>The clinical operations manager validates Professional qualifications, including evidence of registration and scope of practice for registered health practitioners. This includes annual practicing certificates for the pharmacist; general practitioner and other health professionals providing services to residents.</p> <p>New staff receive an orientation/induction programme that covers the essential components of the service provided.</p> <p>The clinical operations manager is interRAI trained.</p> <p>A review of attendance records retained align with the annual training plan and confirm that the training provided meets requirements of the District Health Board contract.</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 are documented and implemented processes that determine staffing levels and skill mix to provide safe service delivery. Staffing considers the layout of the service. The clinical operations manager is onsite five days a week, Monday to Friday.</p> <p>There are 20 staff employed including the clinical operations manager; facility manager (owner); maintenance and oversight of kitchen services (owner); 10 caregivers; kitchen staff and a diversional therapist. There are two caregivers on the morning and afternoon shifts and one overnight. Staffing is adjusted to meet resident needs as required. The clinical operations manager and the facility manager are on call at all times and staff state that they are very responsive.</p> <p>A review of the rosters for the past three months confirmed that staff are replaced when absent. There is also a staff member on each duty with a first aid certificate.</p> <p>The residents and the relative interviewed reported a high level of satisfaction with the skills of the staff and the care provided. This was confirmed by the general practitioner interviewed.</p>
<p>Standard 1.3.1: Entry To</p>	<p>PA</p>	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. The service has a welcome pack that contains all the information about entry to the service. Assessments and</p>

<p>Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>Moderate</p>	<p>entry screening processes are documented and communicated to the family and resident as confirmed by those interviewed.</p> <p>Records sampled did not confirm that admission requirements are completed and signed within the required time frames on entry. The admission agreement should also be reviewed to reflect the District Health Board contract. The improvement required at the previous audit remains.</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>Medication is stored securely with medicines stored in original dispensed packs. Weekly checks and six monthly physical stock takes occur.</p> <p>The health care assistant was observed to give medication to residents and to sign at the time the medication is administered. The clinical operations manager states that the administration sheet is signed by two staff when a controlled drug is administered (noting that there are no controlled drugs in use currently). The pharmacist completes a review of medication six monthly. Stocktakes are completed weekly for controlled drugs as sighted for previous documentation of controlled drugs. Controlled medication can be stored and administered as per policy. Drops/sprays such as eye drops or nasal sprays are dated when opened. The temperature of the refrigerator used to keep medicines in is monitored regularly and in the recommended range.</p> <p>Current medication competencies for staff who administer medicines are current and completed annually. This includes medication competencies for health care assistants and the clinical operations manager. Administration records are maintained, as are specimen signatures.</p> <p>Medication audits have been conducted and corrective actions are implemented following the audits. There is one resident self-administering an inhaler and they are deemed competent to do so. There are daily checks to confirm that the medication is being taken as required. A resident can store their medicines in their room and these are able to be locked in a secure place. The corrective action around self-administration identified at the previous audit has been addressed.</p> <p>The medication files reviewed indicate that the general practitioner reviews the medications as directed and at least monthly or three monthly if documented that this is to occur.</p> <p>As required medication is prescribed correctly with indications for use documented and maximum dose documented. Administration of any as required medication is documented as per policy with no evidence of transcribing.</p> <p>The medication policy, system and procedures comply with the aged care residential medication guidelines and current legislation.</p> <p>A resident prescribed warfarin was reviewed. The medication administration file indicates that the levels are</p>

		<p>checked monthly (INR) or more frequently if the clinical operations manager or staff identify any issues. An example of changes when on antibiotics was sighted with a fax from the general practitioner confirming the dose. Medication administration is recorded along with the dose that matched the INR. The improvement identified at the previous audit has been addressed.</p> <p>Standing orders are documented and have been reviewed by all general practitioners in July 2017. Stock drugs are kept on site and an improvement is required.</p> <p>There is bulk supply of some medication and an improvement is required.</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>Kitchen staff have completed food safety training and cook all meals. The cook is aware of the residents' individual dietary needs and any alerts and allergies are kept in the kitchen. These are updated as changes occur. The nutritional profiles are kept in the resident file and updated on a six-monthly basis or as changes occur. One owner is a chef and they maintain oversight of the kitchen. There are kitchen staff meetings as required with one sighted as being held in 2017.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service and reported their individual preferences are met and adequate food and fluids are provided.</p> <p>Frozen meat is stored correctly in original and appropriate packaging. Meat was observed not be discoloured in any way and is in the original packaging with this dated and covered. The previous improvements identified at the provisional has been addressed.</p> <p>The kitchen environment is clean, well-lit and uncluttered. Fridge and freezer temperatures are monitored regularly and recorded as being within normal range. Food temperatures are taken with these within normal range.</p> <p>There is a seasonal menu with a four-weekly rotation. A review of the menu by a dietitian is not able to be sighted. Review of residents' files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as special diets and soft food if required. Food is available after hours if residents want to access extra.</p> <p>There is enough stock to last in an emergency situation for three days for all residents.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate</p>	<p>FA</p>	<p>Residents receive adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions are documented for each goal in the long-term care plans. Interventions are documented when specific needs are identified, for example, around pain management.</p>

<p>and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>The general practitioner interviewed confirmed that clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long-term care plan as per individual need. This includes support from a podiatrist and assessment service coordinators. Short-term care plans are documented when required for such issues as urinary tract infections, nasal congestion and skin tears. Evidence of resolution of the issue is documented.</p> <p>Care staff document progress notes and observation charts are maintained. Staff confirmed they are familiar with the current interventions for the resident they are allocated.</p> <p>The clinical operations manager documents the assessment and the improvement required at the previous audit has been met.</p> <p>There is evidence in resident files and on incident forms that neurological observations are documented following an unwitnessed fall. The previous improvement required at the previous audit has been met.</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 covers physical, social, recreational, emotional and cultural needs of the residents. The diversional therapist reports that they modify activities based on the resident's response and interests.</p> <p>The residents were observed to be participating in meaningful activities on the audit day. Residents were observed to be going offsite with family/friends, with a number of community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The relatives interviewed reported overall satisfaction with the level and variety of activities provided. Residents confirm that engagement in activities is voluntary.</p> <p>The facility manager, clinical operations manager and the diversional therapist are currently reviewing the programme to offer more individually targeted activities. The current programme is continuing in the meantime with assessment and care planning included as part of the interRAI assessment and review of the long-term care plan.</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>Timeframes in relation to care planning evaluations are documented. In interviews, residents and family confirmed their participation in care plan evaluations.</p> <p>The residents' progress records are entered on each shift with the clinical operations manager documenting at least within 24 hours for residents requiring rest home level care. When resident's progress is different than expected, the registered nurse contacts the general practitioners as required with both general practitioners confirming that staff notify them as soon as changes in a resident's condition has occurred.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if</p>

		<p>this is required.</p> <p>There is a requirement to ensure that six-monthly evaluation and review of the care plan occurs as scheduled.</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>PA Moderate</p>	<p>The building warrant of fitness expires 13 July 2018. There has been no reconfiguration of the building since the previous audit. There have been no changes to the fire evacuation plan and fire drills are conducted six monthly as required.</p> <p>All rooms are of sufficient size to accommodate residents and their activities. Equipment has been tested and tagged within the last year and all medical equipment has been calibrated within the last year. The corrective action identified at the previous audit around testing and tagging of the hoist remains as confirmation of the testing was not sighted during the audit.</p> <p>The service has a planned and reactionary maintenance programme and the owners have completed some refurbishment since the last audit.</p> <p>There are indoor and outdoor areas that enable residents to complete activities and to safely access and navigate through the building.</p> <p>The hot water temperature is checked monthly and remains higher than it should be. The previous improvement identified at the provisional audit remains. There are sufficient numbers of wheelchairs available for resident use as per individual need and the previous improvement identified at the provisional audit has been met.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The clinical operations manager is the infection control coordinator (ICC) and has access to external specialist advice including the general practitioner and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control programme has been reviewed annually and the improvement required at the previous audit has been met.</p> <p>Staff are made aware of new infections through daily handovers on each shift (observed during the audit) and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are</p>

		available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is aligned with the organisation's policies. Infections are recorded for each resident in the resident file. Residents with infections have short term care plans completed to ensure effective management and monitoring of infections. Data around infections and discussion is expected to be reported at the monthly staff meetings with this occurring since the new management of the service (refer 1.2.3). Standardised definitions are used for the identification and classification of infection events. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the clinical operations manager, verbal handovers and progress notes. This was confirmed also through observation of a handover.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. Enabler use is documented in resident care plans as confirmed for one resident. The service has no restraints or enablers in use on the day of audit. All residents using an enabler are described by staff as requiring to give consent for use.

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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>The service is now having regular staff meetings (monthly). In some meeting minutes, there is evidence of discussion of some data. The previous improvement identified at the provisional audit remains.</p> <p>Meeting minutes confirm that there is some discussion of quality improvement information. The previous improvement identified at the provisional audit remains.</p> <p>There is documentation of corrective action plans when issues are addressed for example from internal audit reports completed. The clinical operations manager confirms that corrective actions are put in place when required.</p> <p>The quality and risk management plan is documented but is still to be reviewed. The previous improvement identified at the provisional audit remains.</p>	<p>Quality improvement data is not consistently reviewed for trends with analysis providing opportunities for improvement. The improvement required at the previous audit remains.</p> <p>There is a lack of documented evidence to reflect quality improvement data being communicated to staff. The improvement required at the previous audit remains.</p> <p>There has been no review</p>	<p>Analyse quality improvement data to identify opportunities for improvement.</p> <p>Document evidence to reflect quality improvement data being communicated to staff.</p> <p>Review the 2016 quality</p>

		Quality improvement meetings are to be held monthly with the first one having been held in the last month.	of the 2016 quality and risk management plan as required by the organisational policy. The improvement required at the previous audit remains. The overall risk rating has been raised from low to moderate.	and risk management plan as required by the organisational policy. 90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	The staff files have been left by the previous owners with varying degrees of documentation completed in the past. The facility manager is working through files to coordinate these and to determine which documentation is missing. In files reviewed, all have a signed contract and letter of offer. Other information related to pay is kept on file. The facility manager is planning to address areas still requiring documentation including evidence criminal vetting and documentation of referee checks.	Employee files do not include evidence of criminal vetting and referee checks.	Ensure that all employees have documentation on file including criminal vetting and referee checks. 180 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	A new staff member confirms that they have had a three-day orientation prior to starting in the service. Documentation to confirm this is not sighted. The previous improvement identified at the provisional audit remains. The risk rating remains as low.	Staff files sampled do not evidence of completion of the required orientation programme.	Ensure there is documentation of completion of orientation. 180 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing	PA Low	There is a system to ensure staff receive education with training needs identified through the performance appraisal system. A review of a staff records indicates that performance appraisals are still required to be completed	Performance appraisals are not completed annually as per policy.	Ensure that staff have a performance appraisal at

<p>education for service providers to provide safe and effective services to consumers.</p>		<p>annually. The owner/manager states that they are aware of the improvement required and are intending to address this in 2017. The previous improvement identified at the provisional audit remains.</p> <p>Training for restraint is planned for October 2017 and staff have had training in restraint in June 2016. Staff confirm knowledge of restraint and procedures for managing the one resident using a bed rail. The previous improvement identified at the provisional audit has been met. The restraint coordinator has completed training since the last audit. The previous improvement identified at the provisional audit has been addressed.</p>		<p>least annually as per policy.</p> <p>180 days</p>
<p>Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	<p>PA Moderate</p>	<p>An agreement was sighted for one of the two new residents who have entered the service since the last audit. Agreements for other residents who have been in the service prior to the current ownership were not able to be sighted. It is noted in the previous audit reports that agreements could be sighted.</p> <p>The admission agreement does not align with the ARRC contract such as, the payment schedule around re-payment after discharge is not included in the contract. The previous improvement identified at the provisional audit remains.</p> <p>The risk rating has been raised to moderate.</p>	<p>Agreements are not able to be sighted for all residents including one new resident who has been admitted under the new management.</p> <p>The agreement does not align with the ARRC agreement. The improvement required at the previous audit remains.</p>	<p>i) Ensure that each resident has an agreement.</p> <p>ii) Ensure that the agreement aligns with the ARRC agreement.</p> <p>60 days</p>
<p>Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration,</p>	<p>PA Low</p>	<p>The service has a bulk supply of medicines to be used for standing orders.</p>	<p>The service has bulk supply of medication but is assessed as rest home level of care.</p>	<p>Dispose of the bulk supply of medicines.</p> <p>90 days</p>

review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.				
<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>	PA Low	The owner/manager is not sure that a review of the menu has been completed by a dietician.	A review of the menu by a dietitian is not able to be sighted.	<p>Ensure that there is a review of the menu and resident dietary needs by the diet</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Initial risk assessments are completed on admission. Specialised risk assessments are completed at the initial point of entry with the resident and family involved in documentation of these.</p> <p>The initial interRAI assessment is not always completed in a timely manner for two new residents (files reviewed). The improvement required at the previous audit remains. The clinical operations manager states that the interRAI completed by the needs assessor is also used to form the basis of care plan documentation.</p> <p>All interRAI assessments for residents who require this to be completed six monthly are now up to date.</p>	The first interRAI assessment for a new resident is not completed within three weeks of entry to the service.	<p>Ensure that the first interRAI assessment for a new resident is not completed within three weeks of entry to the service.</p> <p>90 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 intervention, and progress</p>	PA Moderate	Evaluations are expected to be completed every six months. The clinical operations manager) can describe updating of care plans and have been working to ensure the evaluation and subsequent updating of the care plan is completed in a timely manner. The general practitioner states that the staff respond to changes in care.	Two of the files reviewed do not include a six-monthly evaluation and review of the care plan.	Ensure that an evaluation and updating of the care plan is completed six monthly.

towards meeting the desired outcome.		<p>Not all evaluation of care and care plans are reviewed six monthly as scheduled however the service has made progress at addressing the requirement raised at the previous audit around evaluation and review of care plans.</p> <p>InterRAI assessments are now completed for each resident (refer 1.3.3) and these are used to inform evaluation and review of care plan when these are documented. The corrective actions identified at the previous audit has been addressed.</p>		90 days
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Moderate	<p>The clinical operations manager can describe updating of care plans as changes occur. The general practitioner states that the staff respond to changes in care.</p> <p>Not all care plans are updated as changes occur. The corrective action identified at the previous audit remains.</p>	Not all care plans have been updated in response to changes in care.	<p>Ensure that care plans are updated as changes are identified.</p> <p>90 days</p>
<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>Hot water temperature fluctuates around 45 to 54 degrees Celsius. There are two new cylinders with tempering valves and these ensure that the temperatures are within normal range. There is one tank still to address. The owners are working with the external providers to address the issues in the remaining tank. The previous improvement identified at the provisional audit remains.</p> <p>Testing and tagging of equipment is confirmed for all equipment except for confirmation that the hoist has been tested and tagged. The previous improvement identified at the provisional audit has been addressed.</p>	<p>Hot water temperatures are not within 45 Degrees Celsius. The risk rating has been raised from low to moderate.</p> <p>The hoist has not been checked annually as planned.</p>	<p>Ensure that the hot water temperature is maintained within 45 degrees Celsius.</p> <p>Ensure that the hoist is checked annually.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.