

Holmbridge Holdings 1852 Limited - Wakefield Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Holmbridge Holdings 1852 Limited
Premises audited:	Wakefield Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 December 2017 End date: 20 December 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:	15

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.

General overview of the audit

Manis Aged Care No 1 Limited trading as Wakefield Rest Home provides rest home services for up to 22 residents. On the day of audit, there were 15 rest home residents.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owner. The provisional audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, staff and management.

The current owner/manager is an enrolled nurse and supported by a registered nurse, senior caregivers and long serving staff. Residents interviewed were happy with the service and care they receive at Wakefield House.

The prospective owners (one of whom is a registered nurse) reported the current policies, systems and staff will remain in place following the purchase. The current owner/manager is currently on long-term leave but will be available to provide telephone and if able on-site support during the initial transition.

This provisional audit identified areas for improvement around implementation of quality systems including internal audits, essential notifications, aspects of incident management, staff education, staffing, assessment timeframes, care plan documentation and service delivery, referrals, medication, food service and laundry.

Consumer rights

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) are in place. The pack of information given to prospective and new residents includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. There is an established Māori Health plan in place. Discussions with residents and relatives confirm that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. There is an established system for the management of consumer complaints in place.

Organisational management

Current governance arrangements have been in place for just under two years. The owner manager (enrolled nurse) was not onsite on the day of audit and the other owner has a financial background. The clinical manager is also the acting facility manager and has been at Wakefield for fourteen months. A second registered nurse is employed in a caregiver role and between them they manage the on-call commitments. There is an established quality and risk management system in place, which is known to staff. The system includes adverse event management, monitoring of resident satisfaction, the management of infections within the

facility, and the promotion of health and safety. Human resource management practices are conducted in accordance with employment practices and legislation.

Continuum of service delivery

Care plans are developed by the registered nurse with assistance from another registered nurse from a sister facility who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly. There is a medication management system in place. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

Safe and appropriate environment

The building holds a current warrant of fitness. Resident rooms provide single accommodation and there are adequate shower and toilet facilities. Resident rooms are personalised. There are lounges and dining areas. Outdoor areas are available and shading is provided. An appropriate call bell system is available.

There are documented processes for the management of waste and hazardous substances in place. Chemicals are stored safely throughout the facility. Protective equipment and clothing is provided and used by staff. There are cleaning and laundry systems included in policy.

A civil defence/emergency plan is documented for the service. There is a staff member on duty at all times with a current first aid certificate

Restraint minimisation and safe practice

There were comprehensive policies and procedures in place that met the restraint standards. There was a restraint coordinator with delegated responsibilities for monitoring enabler/restraint use and compliance of assessment and evaluation processes. Enabler and/or restraint use was discussed at staff meetings. There was one residents using an enabler and no residents requiring restraint at the time of audit.

Infection prevention and control

The service has infection control management systems in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. The infection control coordinator has attended external education. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	32	0	3	8	2	0
Criteria	0	78	0	4	9	2	0

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

Attainment against the Health and Disability Services Standards

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

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

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

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies and procedures are implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes the Code. Staff receive training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interviews with two caregivers (CGs), and the acting facility manager demonstrated an understanding of the Code. Residents and relatives interviewed (i.e., five rest home residents and two relatives) confirmed that staff respect privacy, and support residents in making choice where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established policies and procedures around informed consent and advanced directives. There are signed consents for release of information, outings and photographs and door names in five resident files sampled. Resuscitation status and advance directives on all files sampled were appropriately signed. Discussions with the acting facility manager, and two caregivers confirmed that they were familiar with the</p>

		requirements to obtain informed consent for personal cares. Discussions with residents confirm that staff seek permission prior to providing cares.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family or EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
<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>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
<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	There is a documented complaints management procedure in place. The acting facility manager has overall responsibility for ensuring all complaints are fully documented and investigated. A complaints register is maintained that includes relevant information. Documentation was available. There has been one documented complaint received in the last two years. The complaint from health and disability was referred to the local DHB and is ongoing. This complaint related to care and maintenance matters. Discussion with residents and relatives confirmed they were provided with information on the complaints process. The complaints policy is posted in a visible area with complaints forms and advocacy information nearby. A complaints procedure was provided to residents within the information pack at entry.

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is an information pack available that includes information about the Code and the nationwide advocacy service. Residents and relatives have the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information were displayed through the facility. The clinical manager discusses the information pack with residents/relatives on admission. Residents and relatives are informed of the scope of services and any liability for payment for items not included in the scope. This information is included in the service agreement.</p> <p>The prospective new owners currently own another small local facility and are experienced in residential aged care. One of the prospective new owners is a registered nurse. Both new owners are knowledgeable in the Health & Disability Commissioner Code of Rights and apply the code of rights in practice in their current roles.</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>	<p>FA</p>	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, care staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. There were instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Interviews with caregivers described how choice is incorporated into resident cares.</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</p>	<p>FA</p>	<p>The service has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs</p>

<p>individual and cultural, values and beliefs.</p>		<p>and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. At the time of audit, the staff reported there were no residents that identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate or able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their culture and values.</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>Staff job descriptions include responsibilities. Staff meetings occur two to four monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the acting facility manager (FM), and caregivers confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has a number of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. Policies are developed by an external contractor and amended as required. A range of clinical and management data are collected. The system of data analysis and trend reporting is designed to inform staff.</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 interviewed reported that staff communicated with them appropriately. There is a policy to guide staff in their responsibility around open disclosure. Staff report incidents and accidents to management. Staff are required to record family notification when recording an incident or accident. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There was an interpreter policy and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Wakefield rest home provides care for up to 22 rest home level residents. On the day of audit there were 15 residents. One resident is under a YPD contract. All other residents are under the aged care contract. The facility manager was on annual leave at the time of audit and the acting facility manager (also the clinical nurse manager) was present for the initial opening audit meeting. There is a business plan (2015-2018).</p> <p>The owners/directors have owned Wakefield rest home since 2014. The owners/directors contract an external age care consultant (registered nurse) to provide support and education for staff.</p> <p>The acting manager has been in the role for six weeks and is supported by a team of caregivers (including one who is a RN). She continues in her role as the full time clinical nurse manager. The acting manager advised that her role is a temporary one until the manager returns. Advised by the acting manager that the directors are available by email or telephone.</p> <p>The manager and the acting manager have attended external education in 2017 and has been supported by an external aged care consultant. The acting facility manager who is a registered nurse manages the organisation. She has a signed contract and a job description for both the acting facility manager and the clinical nurse manager positions. The acting FM reports to the two directors.</p> <p>The prospective new owners (interviewed off site) have work and management experience in residential aged care. The currently own another small rest home in the area. One of the prospective new</p>

		<p>owners is an experienced registered nurse. She has been working as the clinical manager in the district and is experienced in all aspects of clinical management. The two managers will share management roles between the two facilities. All existing staff (other than vulnerable staff) will be asked to reapply for their positions. The prospective new owners will take on an immediate management role including the provision of all clinical and on call support.</p> <p>The expected settlement date is March or April 2018. The DHB is aware of the pending change of ownership. The transition plan confirms there will be no changes to management or clinical systems, policies or procedures during the first year of ownership. The prospective new owner will continue current memberships with established professional bodies.</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>PA Low</p>	<p>The daily operation of the facility is led by the acting facility manager, in consultation with the manager who is currently on leave. The acting facility manager is also employed as the clinical nurse manager when required. The manager has 14 months experience in the aged care industry. If the acting facility manager is unavailable an RN from a sister village in Ashburton can be accessed for support. Contact and communication with the facility manager has not always been available.</p> <p>The prospective owners will manage the facility and support each other where needed.</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 principles.</p>	<p>PA Low</p>	<p>The service has a quality assurance and risk management programme in place and uses an external quality consultant to provide templated policies and procedures, which are then adapted to meet the needs of the facility. The service has a range of policies, associated procedures and forms. Staff interviewed did not fully understand the quality programme.</p> <p>Quality and risk management issues are discussed at the two to four monthly staff meeting. Meeting minutes reviewed included discussion about adverse events and staff training. Policies have specific review dates documented on each policy. All policies were up to date on the</p>

		<p>day of audit. The document review system is managed in consultation with an external contractor. The quality system is based on the PDCA (plan–do–check–act) cycle and meeting minutes evidence discussion of adverse events and infection prevention and control.</p> <p>Quality improvement data is collected, and entered into an online system. Incidents are reported at the general staff meeting. There is a current hazard register in place held a reception. The acting facility manager reports adverse events to the facility manager.</p> <p>Matters arising from the previous meeting is an agenda item in both the resident meeting minutes and the staff meeting minutes.</p> <p>The prospective new owner confirmed on interview that there will be no initial changes to the current quality and risk management system or policies and procedures. The external consultant will be available to mentor the prospective new owner to the quality risk system.</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>PA Moderate</p>	<p>Adverse events are documented and reported to the CM and/or FM or RN on call. These events are initially recorded on hard copy adverse event form (i.e., accident/incident forms). The form is completed, received by the CM and entered into an online system. The original is filed in the resident’s clinical record. Incident numbers are reported at staff meetings. Eight Incidents for the hard copy incidents were reviewed for the month of October and November. Not all incidents were documented or reported. Not all events were recorded appropriately according to policy and not all had been completed with appropriate clinical follow up. The acting facility manager is not fully aware of the requirement to notify relevant authorities in relation to essential notifications (e.g., a wandering resident returned by police).</p> <p>Documents reviewed identified that when the RN determines it is not necessary to contact the family, that this is clearly recorded on the incident form. The adverse events form records if the family have been contacted and the date and time of the contact. Data is collected and entered into an on-line system.</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 resource practice is overseen by the facility manager who is currently on leave. The FM is responsible for rostering and has continued to manage all rostering requirements while on leave with support from the clinical coordinator. There are organisational policies to guide recruitment practices and documented job descriptions for all positions. Appropriate recruitment documentation was seen in the staff files reviewed (which included the clinical coordinator, two caregivers, the activity coordinator and the main cook). Staffing numbers are maintained according to the skill mix policy. All staff receive an orientation that covers essential aspects of service delivery. There was an annual training plan in place, however not all training occurred as planned. The plan includes a range of topics including personal cares, consumer rights, restraint minimisation, safe food handling, and fire safety. Performance appraisals were current in all files reviewed. The workforce turnover is variable and according to staff has been higher than usual over the last two years. Staff interviewed stated that management were not always supportive and responsive to their requests. Staff interviewed spoke positively about training and access to educational opportunities.</p> <p>An education plan is in place, which demonstrates that education is provided on a regular basis. Attendance records are maintained of all staff who attend in-house training opportunities. The registered nurse (i.e., the clinical nurse manager) has a current medication competency assessment. The CGs who administer medicines, have been assessed as competent by the FM or CNM. The CNM and caregivers have current first aid certificates. Not all required education is evidenced as being provided within contractual timeframes. Attendance at on site in service education sessions is not well attended.</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>PA High</p>	<p>There is policy in place that outlines skill mix, staffing and rostering. There was at least one first aid trained member of staff on every shift. The acting facility manager has a current first aid certificate. All senior caregivers have first aid training and are medication competent. Interviews with staff regarding the roster, advised that staffing did not always meet the current needs of the residents. Interviews with</p>

		<p>residents and relatives also indicated there were staffing concerns.</p> <p>The prospective owner stated that all staff other than vulnerable employees will be asked to reapply for their positions. Some of the existing staff will be retained. The prospective new owners have access to experienced care staff to assist with the transition and are planning to review the roster.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so.</p> <p>Individual resident files demonstrate service integration. Entries are legible, dated and signed by the relevant staff member including designation.</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' entry into the service is facilitated in a timely and respectful manner. Pre-admission information on the services is provided for resident and families. Exclusions from the service are included in the admission agreement. Residents and family members interviewed stated that they had received sufficient information prior to and on entry to the service.</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>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs.</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</p>	PA Moderate	<p>There are policies available for safe medicine management that meet legislative requirements. All medications are stored appropriately in a clean, secure, clinical room and medication area. Ten medication</p>

<p>guidelines.</p>		<p>charts were reviewed. All medication charts sampled were legible, up-to-date and reviewed at least three-monthly by the GP. All 'as required' medication charts included an indication for use. This is an improvement on the previous audit. Controlled drug medication was not always checked weekly.</p> <p>The RN and caregivers who administer medications had been assessed for competency and attended education on an annual basis. A caregiver was observed to be safely administering medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. There are no standing orders in use.</p> <p>There is currently one rest home resident who self-administers GTN medication, this is managed appropriately.</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 Moderate</p>	<p>The service employs two cooks who provide meals over seven days a week. There is a small kitchen and all meals are cooked onsite. The cooks maintain a clean and tidy kitchen, however ants are an ongoing issue. The procurement of food for meals has been identified as an issue (link also to 1.4.2.1 for air conditioning). Meals are served from the kitchen, which opens into the dining room. Residents eating in their rooms have meals delivered on trays with the food covered and kept warm. On the day of audit, meals were observed to be hot and family and residents praised the meals. There are a range of policies and procedures to safely manage the kitchen and meal services but no food control plan. Kitchen refrigerator, food and freezer temperatures were monitored and recorded daily. This is an improvement on the previous audit.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets were noted on the kitchen noticeboard, which can be viewed only by kitchen staff. An external dietitian has approved the menus.</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>	<p>FA</p>	<p>Declining entry to services included in policies and procedures. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RN completes an initial assessment on admission including risk assessment tools. An interRAI assessment is undertaken within 21 days of admission. (Link to 1.3.3.3 for less than six monthly reviews). Resident needs and supports are identified through the assessment process in consultation with significant others. InterRAI assessments, assessment notes and summaries were in place for all residents' files sampled that had been at the service for longer than 21 days.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Care plans are individually developed with the resident, and family involvement is included where appropriate. The RN is responsible for all aspects of care planning. Not all care plans included specific interventions for all identified care needs. Not all family/whānau members interviewed were satisfied with the care provided. Assessments and care plans included input from allied health including the GPs, nurse specialist, and podiatry. Physiotherapy is available if needed.</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 High</p>	<p>The registered nurse and caregivers follow the care plan and report progress against the plan at least daily or more frequently if needed. If external medical advice is required, this will be actioned by the GP. Staff report they have access to sufficient continence products and resident files include a continence assessment and plan.</p> <p>There were six documented wounds at the time of audit. Wound care was undertaken by the caregivers who report the RN if there are any issues identified. A review of the process, practice and documentation of wound care evidences a need for improvement. Wounds included; multiple scratches for one resident, and another resident with a skin</p>

		<p>lesion.</p> <p>Interviews with the registered nurse and care givers demonstrated an understanding of the residents in their care, but not all care interventions needed. Monitoring charts are not always completed as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activity coordinator provides activities 15 hours a week (Monday to Friday) with the flexibility to increase hours for outings as required. She has been in the role since February 2015 and has commenced diversional therapy training and attends regional diversional therapy (DT) meetings/workshops regularly. The activity coordinator has a current first aid certificate. The group activity programme is planned a month in advance. Activities for the week are displayed. Regular entertainers visit the home and there are links to a local school and community to involve them in activities with the residents. Church services (interdenominational) are held on-site fortnightly. There are regular outings into the community. There is a range of activities to meet the recreational preferences and individual abilities of the residents. One-on-one time is spent with residents who choose not to participate in the group programme. The activities coordinator completes a resident social profile and activities assessment on admission. Each resident has an individualised activity plan which is reviewed six monthly. Three monthly resident meetings provide an opportunity for the residents to provide feedback and suggestions on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans reviewed were evaluated and a MDT review at least six monthly (link to 1.3.3.3 for interRAI reviews). There was at least a three-monthly review by the GP in these files. Care plan reviews are signed by the RN in files sampled.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	PA Moderate	<p>The RN was able to describe access to other medical and non-medical services. Two residents had documented referrals to hospital level care</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>		<p>and staff were able to describe the care and support for these residents. Two further residents, one with a choking risk and one with deteriorating mental ability and wandering had no referrals in place. Referral documentation is maintained on resident files. The registered nurse initiates referrals to nurse specialists and allied health services. Other specialist referrals were made by the GP. Access to the physio is also available.</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>	<p>FA</p>	<p>There are policies and procedures in place for the disposal of waste and hazardous material. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties.</p> <p>All chemicals sighted were appropriately stored in locked areas. Chemicals are appropriately labelled. Material safety datasheets are available. Infection control policies state specific tasks and duties for which protective equipment is to be worn.</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 holds a current warrant of fitness, which expires 19 April 2018.</p> <p>The service employs a maintenance person for five hours a week. He has been in the role for a month. A sample of hot water temperatures are taken monthly, and these are maintained at (or just below) 45 degrees. The facility's amenities, fixtures, equipment and furniture are appropriate for the level of service contracted, however there is no preventative maintenance documented and the maintenance person was unaware of any process around this. Not all required maintenance has occurred as required. The air conditioner and the waste disposal unit in the kitchen are not in working order. Two toilets and two bathrooms need repairs to walls and floors (link also to 1.3.13.5 for pest control).</p> <p>There is sufficient space to allow residents to move around the facility freely. The hallways are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are</p>

		<p>designed so that space and seating arrangements provide for individual and group activities. Residents' bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are maintained. There is a designated outdoor smoking area.</p> <p>The prospective new owners confirmed on interview that a refurbishment programme and all required maintenance will be commenced during the first year of ownership.</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>All bedrooms have hand basins. There are adequate numbers of communal toilets and showers for residents. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Residents confirmed their privacy is maintained at all times (link to 1.4.2.1 for repairs of toilets and bathrooms).</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>All bedrooms except one are single occupancy. The double room was occupied by a married couple on the day of audit. The rooms are spacious enough for the resident to easily manoeuvre around with mobility aids as required. Residents are encouraged to personalise their rooms as desired.</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>There is a large open plan lounge and dining room, which can be closed off with a large folding door. All communal areas are easily accessed. There are several seating alcoves. There is adequate space to allow for individual and group activities to occur within the lounge.</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>	PA Moderate	<p>There is a cleaning policy and cleaning schedules in place. Personal protective equipment is available in sluice, cleaning and laundry room. There is a defined clean and dirty area within the laundry with an entry and exit door. There were adequate linen supplies sighted. The cleaning trolley is stored in a locked sluice room when not in use.</p>

		Safety data sheets are available for cleaning and HCAs who complete laundry duties. Staff were observed to be wearing appropriate protective wear when carrying out their duties. The implementation of cleaning and laundry processes was not in place with the level of cleanliness and provision of linen for residents not up to standard.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The facility has an Emergency Management plan, which includes guidance to staff on how to respond to a range of civil defence emergencies. The plan includes contact numbers of contractors and key staff contact numbers are listed in the nurses' station. There is a first aid trained staff member on every shift. There is an approved fire evacuation plan in place and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (the kitchen has electric power and there is a gas BBQ available in the event of a power failure). Emergency lighting is in place, which will last for approximately four hours. The building has diesel heating and a diesel generator. There is civil defence equipment in the garage and stored drinkable and non-drinkable water on site. Electronic call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. There are internal closed-circuit cameras in the corridors. The facility is secured at night and there is external security in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms and communal areas are well ventilated and light. The facility has under floor heating. The residents confirmed the temperature of the facility is comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection prevention and control (IPC) programme is appropriate for the size and complexity of the service. The acting facility manager (RN) is the infection prevention and control officer and there is a job description in place for the position. The facility has a suite of infection prevention and control policies. The infection prevention and control practices are authorised and reviewed annually by the facility manager. The infection prevention and control programme results are discussed

		at the general staff meetings. (Link to 1.2.3.6).
<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	The acting facility manager (who is an RN) is the infection prevention and control coordinator. The facility has developed links with the local medical practice that is situated next door, the laboratory, the infection control and public health departments at the local DHB.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection prevention and control officer (acting facility manager) is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions and training was provided both at orientation and as part of the annual training schedule. Resident education was expected to occur as part of providing daily cares. The acting facility manager has completed training in infection control.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy is included in the IPC programme. Individual infections are recorded in a register and documented in clinical records. Monthly data is collated and reported to the general staff meetings. The type of surveillance undertaken is appropriate to the size and complexity of the service. The infection rate is low. There have been no outbreaks since the last audit.</p> <p>Policies and procedures document infection prevention and control surveillance methods. Surveillance data is collected and analysed monthly, to identify areas for improvement or corrective action requirements (link to 1.2.3.6). Infection control internal audits have</p>

		been completed. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The policy identifies that restraint is used as a last resort. The service had no residents using restraints and one resident using an enabler on the day of audit. The acting facility manager and care staff are aware that enablers are to be used voluntarily. Restraint minimisation is discussed at the general staff meeting.

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 1.2.2.1</p> <p>During a temporary absence a suitably qualified and/or experienced person performs the manager's role.</p>	PA Low	<p>The facility manager (FM) is an enrolled nurse with experience in the aged care industry. The FM has ownership and interest in a sister facility in Ashburton. The FM is currently on leave. Prior to this unplanned leave, the manager was at Wakefield Tuesday to Thursday on alternate weeks. The CNM has a job description for her additional role as acting facility manager.</p>	<p>Staff and family inform that the FM is not readily available, and communication is difficult (Prior to this unplanned leave, the manager was at Wakefield Tuesday to Thursday on alternate weeks). The acting facility manager does not have the experience, time authority to fully manage the facility. The current acting facility manager also full fills a caregiving role when necessary.</p>	<p>Ensure suitably qualified and experienced facility managerial support is available</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the</p>	PA Low	<p>A system is in place to document all incidents. Data is collected and entered into an online tool. Further analysis and trending is available on line</p>	<p>(i)Quality data is being entered into an on-line system, however there is no evidence the system is being used for trending and analysis; (ii) Meeting minutes reviewed do not fully inform staff</p>	<p>(i)Ensure the incident data entered into the system is reviewed, analysed and trends identified; (ii) Ensure quality improvement and adverse event data is communicated to staff</p>

results communicated to service providers and, where appropriate, consumers.		and can be accessed as needed. The system is not fully implemented.	of trends and adverse events; (iii) Survey results distributed to residents and families in October have not been correlated, analysed or reported.	and residents (where appropriate); (iii) Correlate, analyse survey results and report back to staff, residents and family. 90 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 Low	The quality policy and process document a corrective action process; however this was not being fully implemented.	(i)Internal auditing has not been fully completed as per the internal audit plan; (ii) Completed internal audits results are not always reviewed and signed off by the manager; (iii) There is no evidence of a corrective action process being implemented where shortfalls are identified.	(i)Ensure the internal audit schedule is adhered to; (ii) Ensure completed audits evidence review by the facility manager; (iii) Ensure a corrective action process is implemented where internal audits identify shortcomings. 90 days
Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.	PA Moderate	The acting facility manager (FM) was not fully aware of the requirement to notify relevant authorities in relation to essential notifications (e.g., a wandering resident returned by police). A resident had absconded three times.	The Acting FM was unaware of the need to document police involvement where a resident has gone missing. Section 31's had not been completed and the contract manager had not been informed (link 1.3.5.2 and 1.3.9.1).	(i)Ensure all incidents are documented as per policy; (ii) Ensure neurological observations are implemented for residents who have potentially hit their head. 30 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to	PA Moderate	Policy clearly identifies that all incident and accident are documented on the designated form and reported to the FM, CM or RN. However not all incidents had documented incident forms completed. Neurological observations were	(i)One resident with multiple incidents of wandering and challenging behaviour did not have incident forms documented for these events; (ii) Five of seven residents with unwitnessed falls did not evidence neurological observations were implemented as per policy.	(i)Ensure all incidents are documented as per policy; (ii) Ensure neurological observations are implemented for residents who have potentially hit their head. 90 days

improve service delivery, and to identify and manage risk.		not routinely completed where the resident had potentially hot their head.		
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	An education plan is documented as part of the quality system. At least eight hours is offered annually, however not all mandatory training has been provided.	(i)Not all required education has been provided as per contractual requirements. Staff have not received training in safe handling and transfers, continence, pain management, challenging behaviour, falls management, health and safety and chemical safety; (ii) Attendance rates at in-service education sessions is less than 50% for eleven of sixteen documented in-service sessions'	(i)Ensure education planning includes all required education as per contractual requirements and resident current needs; (ii) Ensure those staff that do not attend training are monitored and alternative information/education provided. 60 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA High	The current roster evidenced sufficient staff to meet the needs of rest home resident level of care residents. The acting facility manager (who was the CNM) has been employed in her role for 14 months since graduating from a CAP program. The RN can receive clinical support from the CNM at a sister village in Ashburton. The acting facility manager works 40 hours per week, Monday to Friday and is currently covering for the FM who is on leave.	(i)Staffing does not meet the needs of continuing care residents currently residing at the facility. Two residents (including one YPD) have only recently been reassessed as hospital level care and a further resident requires reassessment due to safety and risk of absconding. (ii)There is currently one resident who requires the use of a two-person sling hoist for mobilisation. From 9 pm to 7 am and on other occasions there is only one staff member rostered on duty. At these times, care staff utilise another resident to assist with sling hoists (also link 1.3.5.2); (iii) The caregivers advised that the care nurse manager (CNM) often works in a caregiver role during the day when care staff are on leave. The CNM agreed this	(i)-(iii) Staffing has not been adjusted to meet the current acuity levels of residents; (iv) ensure there is clinical oversight and support for the CNM. 7 days

			was correct; (iv) The acting facility manager (also CNM role) has no readily accessible clinical support arrangements/mentoring in place (The CNM has been employed in this role for 14 months since graduating from a CAP programme).	
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA Moderate</p>	<p>Medication charts reviewed identified that controlled drugs' were appropriately prescribed. Signing charts and the controlled medication register documented two staff always sign for medication. There have been no weekly checks of the controlled drug register.</p>	<p>The controlled medication register had not been stock checked weekly.</p>	<p>Ensure that the controlled medication register has a documented weekly stock check</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Moderate</p>	<p>The cook maintains a cleaning schedule, and this was observed on the day of audit. Food temperatures and fridge and freezer temperature are documented. Shortfalls were identified around the food service.</p>	<p>(i)There was no food control plan being implemented; (ii) The audit team were advised by the cook and other members of staff that they have been unable to order food on the day of audit due to financial constraints set by the supplier. Staff advised that they are not able to follow the set menu on more than one occasion due to this issue; (iii) The kitchen (and other areas of the home) have an ant problem. It was advised that this was being addressed, but there was no pest-control documentation to support this. A photo taken on the day of audit evidenced that the cook needed to clean the kitchen prior to cooking due to ants over the surfaces.</p>	<p>(i)Ensure a documented food control plan is implemented; (ii) Ensure that supplies are available to enable the set menus to be followed; (iii) Ensure that pest control is implemented</p> <p>30 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>	<p>PA Low</p>	<p>The service undertakes a range of paper based assessments and interRAI on admission to services and reviews long term care plans six monthly; these were all completed in a timely manner. Four of five files had a recent interRAI completed resident (one was a YPD). Previously, there at been a yearly gap between interRAI's being completed.</p>	<p>Four residents (under ARCC contract) reviewed did not had six monthly interRAI assessments completed over the last year.</p>	<p>Ensure interRAI assessments are undertaken and documented six monthly or when health status changes.</p> <p>60 days</p>
<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 Moderate</p>	<p>Long-term care plans were documented by the registered nurse. All residents had a long-term care plan in place. Caregivers were knowledgeable about the individual resident care needs. The care plans documented the resident health conditions, but not the interventions associated with the condition.</p>	<p>(i)One resident file did not reflect the risk and interventions needed associated with a high wandering risk. The care plan documented the need for monitoring, but not how often and what monitoring was needed. This resident (who has a history of refusing care and behaviour that challenges) did not have this documented in the care plan or interventions to manage. (ii) One resident did not have interventions to manage pain, use of the wheelchair and reclining chair as directed by the physio. (iii) One resident did not have documented the type of sling and hoist to be used, the interventions needed for frail skin, swollen and care and support needed for an ostomy. (iii) One resident did not have nursing interventions to support anxiety, (only medication interventions). The same resident had no interventions for an identified choking</p>	<p>Ensure that care plans have interventions and care documented for all resident needs</p> <p>30 days</p>

			risk, Parkinson's or postural hypotension.	
<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>	PA High	All identified wounds had a wound plan in place, but not all reflected the wound or care interventions documented. Staff were evidenced to be caring and attentive to residents with resident and family member agreeing that caregivers were kind and caring. Monitoring of resident to ensure their safe and effective care was not always documented or implemented.	<p>(i) Four wound care plans were documented in the wound file that had no assessment/evaluation for many months. Staff stated the wounds have all healed, but this was not documented and is still current in the wound folder.</p> <p>(ii) Two residents had more than one wound per wound assessment and plan.</p> <p>(iii) One wound stated, 'sensitive skin' but on review, it was a lesion. This same wound has no wound management process, but stated 'infected', the management of the lesion is not stated, and there is an inappropriate intervention for topical applications.</p> <p>(iv) The wound care files and the wound trolley were noted to be unclean, with previous used dressings on the trolley throughout the audit day.</p> <p>(v) Bandages were noted to be washed and re-used (shared).</p> <p>(vi) There was no monitoring of pain for one resident (where pain was an issue).</p> <p>(vii) One resident's partner (also a resident in the home with dementia) assists with hoisting (rather than a second carer – link 1.2.8.1).</p> <p>(viii) One resident with a high risk of wandering has no formal monitoring despite numerous episodes of being brought back to the home by police and members of the public. It was noted that for all but one of these episodes the facility had not noticed the resident was missing.</p> <p>(ix) There is no behaviour monitoring for one resident with documented behaviours that</p>	<p>(i) Ensure wounds are evaluated at each dressing changed and closed out when healed; (ii) Ensure that each wound has an assessment and management plan; (iii) Ensure wound assessments and plans reflect the wound and provide treatment appropriate to its care; (iv) and (v) Ensure standard precautions and infection control processes are implemented; (vi) Ensure that pain is documented as monitored when pain has documented as an issue; (vii) Ensure that only staff who have undertaken manual handling training assist resident with a hoist; (viii) Ensure that resident who have a high-risk wandering are monitored and staff are aware of their whereabouts always to ensure their safety; and (iv) Ensure that behaviour is monitored and evaluated.</p> <p>7 days</p>

			challenge.	
<p>Criterion 1.3.9.1</p> <p>Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.</p>	<p>PA Moderate</p>	<p>Two residents with identified higher needs had a documented referral in place for a different level of care. The resident's files documented that this had been discussed with them. Staff interviewed were aware of the higher needs for these residents</p>	<p>(i)One resident with a documented high risk of choking had not been referred to the speech language therapist; (ii) One resident who required referral to a higher level of care (wandering and behaviour) had no referral in place. (this was referred to the GP on the day of audit who placed a referral). Also link 1.3.5.2.</p>	<p>Ensure that residents assessed as requiring other services are referred to specialists/allied health/needs assessors as needed to ensure safe and effective care</p> <p>30 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>Scales and hoists document that they have been checked and calibrated for 2017. There is a current building warrant of fitness in place. The facility's amenities, fixtures, equipment and furniture are appropriate for the level of service contracted, however there is no preventative maintenance documented and the maintenance person was unaware of any process around this. Not all required maintenance has occurred as required.</p>	<p>(i)In the kitchen the air conditioner and waste disposal unit are broken; (ii) Two bathrooms and two toilets flooring and / or wall covering need repair</p>	<p>(i)Ensure that preventative and reactive maintenance are in place and ensure that floors are walls are in a good state of repair; (ii) Ensure that all equipment is maintained in working order</p> <p>60 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for</p>	<p>PA Moderate</p>	<p>There are policies, and process documented to ensure safe and hygienic services. However, on the day of audit these had not</p>	<p>The level of cleanliness within the facility was not up to standard. This was stated by three of four relatives and all staff interviewed. On observation it was noted that; carpets were stained, chairs</p>	<p>Ensure that cleaning and laundry services are implemented and audited to ensure services are clean and well maintained</p>

<p>cleaning and laundry processes are monitored for effectiveness.</p>		<p>been implemented</p>	<p>were not clean with stains and detritus under cushions, two toilets and two showers were not clean and one over bed table. The laundry was also not clean. Resident towels sited were frayed and worn.</p>	<p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.