

Wellness Enterprises Limited - Raglan Rest Home and Hospital

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

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

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

The specifics of this audit included:

Legal entity:	Wellness Enterprises Limited	
Premises audited:	Raglan Rest Home and Hospital	
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 11 January 2018	End date: 12 January 2018
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:	22	

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

General overview of the audit

Raglan Trust Hospital and Rest Home provides rest home and hospital level care for up to thirty six residents. The service has been operated by Ki-Chi service Supplies Company since 2002. The sale and purchase agreement with Wellness Enterprises, the prospective provider is anticipated to be enacted in March 2018. The facility is currently managed by a full time employed facility manager who is a registered nurse. This person also oversees the clinical care provided. Residents and families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, contracted allied health providers and a general practitioner.

This audit revealed eight areas requiring improvement relating to informed consent, staff training, the admission process, assessments and care planning, medicine management, the environment, emergency preparedness and quality review of restraints. Action has been taken to address all the areas requiring improvement at the previous surveillance audit.

Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

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

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident and family.

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

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

Medicines are administered by staff who are competent to do so.

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

Safe and appropriate environment

The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness.

Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Four restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	42	0	8	0	0	0
Criteria	0	93	0	8	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>	PA Low	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form; however, this consent form does not include the sharing of resident's information or permission to provide medical treatment (which is found in the admissions agreement, see criterion 1.3.1.4). Advance care planning, establishing and documenting enduring power</p>

		of attorney requirements and processes for residents unable to consent is defined and was documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.
<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	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The facility manager/clinical manager provided examples of when they would involve Advocacy Services and/or encourage the resident and/or family to do so.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Three residents partake weekly in community activities, the facility supporting this with facilitation of transport.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns.</p> <p>The complaints register reviewed showed that six complaints have been received over the past year and that the actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff</p>

		interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints investigated by the office of the Health and Disability Commissioner since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	<p>The prospective provider is an experienced aged care sector provider. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the requirements of the Code as part of their existing roles</p> <p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in main corridor together with information on advocacy services, how to make a complaint and feedback forms are at reception.</p>
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by attending community activities and arranging their own visits to the doctor. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The facility manager/clinical manager interviewed stated that there were currently no residents who affiliate with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori, with staff able to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. There is no specific current Māori health plan, however all values and beliefs are integrated throughout the long-term care plans with input from cultural advisers within the local community. Guidance on tikanga best practice is available and is supported by staff in the facility and a local kaumatua group also visits the facility fortnightly with a singing group.</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>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate</p>

		<p>medical intervention when required and staff were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to speak English, staff being able to provide interpretation as and when needed, and the use of family members.</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>	FA	<p>The strategic and business plans, which are now reviewed quarterly, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the owner showed adequate information to monitor performance is reported including occupancy, financial and staff performance, and any emerging risks and issues.</p> <p>The service is managed by a facility manager who also acts as the clinical manager. This person holds nursing qualifications and has been in the role for two years. Responsibilities and accountabilities for the manager are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending regular forums with sector peers and ongoing education.</p> <p>The service holds contracts with Waikato DHB and the Ministry of</p>

		<p>Health (MoH) for Young People with Disabilities (YPD). Two YPD residents were receiving services under the contract and comprise a total of 12 residents for hospital level care and 10 for rest home level care.</p> <p>A business plan and actions for transition have been developed by the prospective owner. This person is a New Zealand registered nurse with 15 years' experience in the local health sector which includes 10 years in nursing and management roles in aged care services. Telephone interview revealed there is an agreement with the quality consultant who has been providing support to the facility to assist in the transition period. The existing owner has agreed to a two week handover process. There is no intention to change the current staffing, with the exception of the nurse manager role which will be taken up by the prospective owner. All existing systems including the relationship with an associate group, the Cavell Group, will remain in place during the transition period. It is expected that existing staff will transfer to the new provider.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the facility manager is absent, the senior RN carries out all the required duties under delegated authority. The clinical management is overseen by the facility manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>The prospective provider has no plans to make any significant staff changes during the transition period. Existing cover arrangements for the day to day operations will remain in place, with access to the current owner for the initial two weeks. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.</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</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular</p>

<p>quality improvement principles.</p>		<p>resident and relative satisfaction survey, monitoring of outcomes, and clinical incidents including infections.</p> <p>The document control system, which is moderated by all managers of the Cavell Group, ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at staff meetings. The facility continues to provide monthly quality and risk data for benchmarking with the other aged care facilities in the Cavell Group and current month by month comparisons and analysis are provided for the facility care staff. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. More in-depth audits in medicines, staffing, cleaning and food services recently conducted by the quality consultant have resulted in changes to processes where a need for improvement were identified.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities and discussion of results at meetings. Resident and family satisfaction surveys are completed annually. The most recent survey showed an increase from 37% in 2016 to 62% in the overall satisfaction rating.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>The prospective owner stated an intention to maintain the current quality and risk system during the transition period.</p>
<p>Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported monthly to the Cavell Group for benchmarking. The facility's monthly reports provide key information for discussion at staff meetings.</p> <p>The facility manager described essential notification reporting requirements. They advised there have been no notifications of significant events made to the Ministry of Health, or the district health board since the previous audit. There has been one report to the NZ Nursing Council in 2016.</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner interviewed, is aware of all current health and safety legislative requirements and the need to comply with these. The interviewee was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.</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 Low</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. New methods for orientation have been introduced recently and staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. There is a requirement to provide staff with regular education in safe restraint use; this is not occurring. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The facility manager is trained and maintaining annual competency requirements to undertake interRAI</p>

		<p>assessments and another of the RNs is close to completing the training. The resignation of RNs with these competencies has contributed to a delay in completing some assessments. Refer corrective action in criterion 1.3.3.1. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. A review of staffing utilising different models and a time and motion study was recently conducted by the quality consultant. This resulted in an increase in cleaning staff hours and confirmed adequate staff numbers for the needs of the current number of residents. Care staff reported there were sufficient staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on each duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage as required for hospital level care.</p> <p>The prospective owner stated intention is to maintain the current staffing levels and skill mix.</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>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident</p>

		information was on public display during the audit.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	PA Low	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Disability Support Link (DSL) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from DSL and/or the GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments however not all residents admitted to the facility have a signed and dated admission agreement in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. The facility manager/clinical manager interviewed stated that they have not admitted a resident acutely to an acute care services in approximately 15 months.</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>	PA Low	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a paper based system was observed on the day of audit. The staff observed demonstrated</p>

		<p>good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All blister packed medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement, however not all medications discontinued were crossed off and signed and dated by the GP. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There is one resident who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a qualified cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service is currently developing a food safety plan for</p>

		<p>approval and was aware of the final submission date of March 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Residents and family interviewed stated that they are not always satisfied with the meals provided. The facility manager/clinical manager interviewed stated that they are working with the kitchen and residents to ensure resident satisfaction with meals. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local Disability Support Link (DSL) Service is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the DSL is made and a new placement found, in consultation with the resident and whānau/family. There were no examples of this occurring. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform initial care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed. The facility manager/clinical manager is interRAI trained, however currently not completing interRAI</p>

		assessment, and one RN is currently in training. Residents and families confirmed their involvement in the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and is verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents young and older and was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs and ability.</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 activities programme is provided by an activity co-ordinator (not available at the time of audit for interview), currently completing a diversional therapy qualification, and is supported by a volunteer who has a background in diversional therapy. The activity co-ordinator works Monday to Friday from 9 am to 2.30 pm. The volunteer works two days a week and also supports the residents' weekly community van outings.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements.</p>

		<p>Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents both young and older and consistent with their interests and preferences. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme enjoyable.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to a wound specialist, physiotherapist, ostomy and continence nurse specialists. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are</p>

		attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>All staff who handle chemicals have completed safe chemical handling training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Appropriate signage is displayed where necessary.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>A current building warrant of fitness expiring on 27 April 2018 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Testing and calibration of hoists and bio medical equipment occurs regularly. The testing and tagging of other electrical equipment has not been carried out for two years; there is a requirement to do this. The environment is hazard free, residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>The prospective owner stated there is an intention to make upgrades to the interior of the building but not in ways that will change the structure or layout.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes eight bedrooms with shared ensuite bathrooms and four other bathrooms. Staff and visitors toilets are separately designated. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</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>	FA	<p>Laundry is undertaken on site in a dedicated laundry. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff have been provided with training in safe handling of chemicals and general health and safety education, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit</p>

		programme. A recent review of cleaning services has resulted in improved processes and an increase in cleaning staff hours.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 03 May 2015. The frequency of trial evacuation drills requires improvement. The orientation programme includes fire and security training.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the maximum number of residents (thirty six). Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. There is closed circuit television monitoring throughout the facility which residents and families are aware of and have agreed to.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, and opening external windows. Heating is provided by a combination of radiators and panel heaters in residents' rooms and in the communal areas. There is a heat pump in the large lounge. Areas were well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature during all seasons.</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 implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from clinical nurse specialists. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator (newly appointed) with support from the facility manager/clinical manager whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager/clinical manager, owner, governing body and tabled at health and safety and staff meetings. This committee includes the facility manager/clinical manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>The facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility and signage is put up at all entrances to the facility in the winter months. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for one week. She has undertaken certificates in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good</p>

<p>of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>practice. Policies were last reviewed in July 2017 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility manager/clinical manager, IPC committee and at staff meetings. Data is benchmarked externally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector with a total of nine infections for the</p>

		facility since August 2017.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, four residents were using restraints (eg, fall out/tub chairs and one person requiring bed rails), no residents were using enablers. A similar process is followed for the use of enablers as is used for restraints. The contracted physiotherapist and physiotherapist assistant interviewed, described the strength and balancing programmes in place for individual residents to maintain their mobilisation and prevent falls.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint register, files reviewed, and from interviews with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval group, made up of the facility manager/clinical manager and the general practitioner, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the individual use of restraints is being monitored. Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The restraint coordinator described the</p>

		documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds and tub chairs).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed by the restraint coordinator every three months. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff meeting minutes show that use of restraint, policy and procedures and related topics is discussed frequently but there has been no formal education for two years. There is a requirement for improvement in Standard 1.2.7 related to this. Staff spoken to understood that the use of restraint was to be minimised and how to maintain safety when in use.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed by the restraint coordinator every three months and evaluated during care plan and interRAI reviews. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>PA Low</p>	<p>The restraint coordinator undertakes three monthly reviews of individual restraint use but there has not been a formal quality review of the overall restraint usage at Raglan Trust or other component parts of this Standard that meets the requirements. There have been changes to monitoring policies and processes.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Low	<p>The facility’s general consent form includes permission for outings, attending planned entertainment, photos and excursions with specific people other than staff. All residents and family interviewed stated ‘they are happy with the way they are treated and the option of choices’. On the day of audit, staff were observed to gain consent for day to day care. The residents’ progress notes showed evidence of conversations with family members and copies of the admission agreement have been sent out to the families/EPOA several times. Five of six residents’ files reviewed had the general consent forms signed by the resident and advance care planning signed and supported by the GP; however, three residents admitted to the facility in June, July and September of</p>	<p>Three of five residents’ files reviewed had no evidence that the consent for the sharing of medical information between health professionals and permission for medical treatment (which is acknowledged within the admission agreement), had been signed by the resident, if deemed competent, or EPOA.</p>	<p>Ensure that general consents are fully completed and appropriately signed to meet contractual requirements.</p> <p>180 days</p>

		2017 (one of the three being deemed incompetent to make a decision), have not provided or had provided by their EPOA consent for the sharing of medical information between health professionals and permission to provide medical treatment has not been obtained.		
<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 Low	Staff training calendars and staff interview demonstrate that education on a range of topics is provided every month. Planning and provision of education related to minimisation and safe restraint practice is not on the calendar and has not occurred for two years.	Formal education and training on the minimisation and safe practice of restraint is not occurring.	<p>Ensure staff attend regular training and education on minimisation and safe restraint use.</p> <p>180 days</p>
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Low	All residents and family interviewed stated that they were provided with an information pack on admission providing information about the admission agreement and requirements of entering the facility. The residents' progress notes show evidence of conversations with family and copies of the admission agreement have been sent out to the families/EPOA on more than one occasion; however, three residents admitted to the facility in June, July and September of 2017 (one of the three being deemed incompetent to make a decision), have not provided or had provided by their EPOA a signed admission agreement.	Three of five residents' files reviewed did not have an admissions agreement signed; two of the three residents were deemed to be competent.	<p>Ensure that all admission agreements are completed and signed by the resident if deemed competent or the EPOA to meet contractual requirements.</p> <p>180 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>All 22 medication charts had a photo identifying the resident, all allergies noted and a GP signature and date for all commencement of medication. All pro re nata (PRN) medications had the reason indicated for medication documented. However, one resident had two medications, two residents had six medications, two residents had one medication and one resident had four medications not appropriately discontinued by a GP on the medication drug chart for short term medications.</p> <p>All medications were locked in the medication trolley and then locked in the treatment room. All staff responsible for medicine management has been assessed as competent to perform the function for each stage they manage. In observing the medication trolley, two eye drop medications were opened and dated 29 April 2017 and were now expired, and two eye drop medications were not dated when opened. The registered nurse interviewed stated that she was aware of the policy required and discarded all four medications in the pharmacy impress return box.</p>	<p>Six of 10 medication files reviewed had short term course medications charted which were no longer required. These were not crossed off, signed and dated as discontinued.</p> <p>In observing the medication trolley, two eye drop medications were expired and a further two eye medications were not dated when opened.</p>	<p>Ensure that all medication charted and no longer required is crossed off and signed and dated by the GP. Ensure that all medications are dated when opened and discarded prior to the given expiry date.</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</p>	<p>PA Low</p>	<p>All 22 residents have individual, detailed and client specific initial care plans and long-term care plans. Five staff trained in interRAI have since left the facility. The RN currently training in interRAI has</p>	<p>Thirteen (13) of 22 residents did not have an up to date interRAI assessment.</p>	<p>Ensure that all interRAI assessments are completed with the required timeframes.</p>

frames that safely meet the needs of the consumer.		been provided two days a week to focus on interRAI. Currently there are 13 residents who do not have an up to date interRAI assessment with one resident admitted in July 2017 awaiting file transfer from Disability Support Link. Five interRAI assessments were due in September, four due in October, two in November, and two were due in December of 2017. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and family members interviewed stated that they were very happy with the care provided.		180 days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	Staff interviewed and review of maintenance records revealed that registered electricians are used for reactive repairs to electrical equipment, but there has been no general testing and tagging since February 2016.	Testing and tagging of electrical devices is not occurring regularly.	<p>Ensure all 'plug in' electrical devices are tested at regular intervals.</p> <p>180 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Low	The most recent trial evacuation took place on 11 April 2017 with a copy sent to the New Zealand Fire Service. This was due to be repeated in October but three services including the fire service contacted to conduct this, were unavailable. This is now scheduled for January 17th 2018. Staff confirmed their awareness of the emergency procedures.	Trial evacuation drills are not occurring as required at six monthly intervals.	<p>Ensure fire evacuation drills occur at least six monthly.</p> <p>180 days</p>

<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <ul style="list-style-type: none"> (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education. 	<p>PA Low</p>	<p>Interview with the restraint coordinator confirmed regular review of individual restraint interventions and there has been policy and process amendments. A comprehensive review of all restraint practices within the service to determine trends (positive and unwanted), adherence to policy and procedures and staff educational needs, has not occurred.</p>	<p>There is no evidence of a quality review of the service approach and outcomes with restraint practices.</p>	<p>Ensure that a formal quality review which takes into account all of the criteria required in the standard, occurs at least annually.</p> <p>180 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.