

Agape Care Warkworth Limited - Leigh Road Cottage

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Agape Care Warkworth Limited	
Premises audited:	Leigh Road Cottage	
Services audited:	Dementia care	
Dates of audit:	Start date: 23 January 2018	End date: 24 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:	18	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Leigh Road Cottage provides residential care for up to 30 residents. On the first day of this audit 18 beds were occupied. The facility is operated by Agape Care Warkworth Limited and is privately owned.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with one resident, families, management, staff and a general practitioner. Further residents were not able to be formally interviewed.

Areas identified as requiring improvement relate to the management of complaints, currency of policies and procedures, human resources management, specific education for the infection prevention and control coordinator, qualifications of the activities coordinator, controlled drugs management, review of the menu, aspects of the physical environment and safe and accessible external areas for residents.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Some standards applicable to this service partially attained and of low risk.

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

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent. The service demonstrated good understanding about the need for Enduring Powers of Attorney (EPOA). All residents had a nominated EPOA.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was 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 management policy meets Right 10 of the Code. There have been no complaint investigations by the Health and Disability Commissioner or other external agencies since the previous audit. The facility manager is responsible for the management of complaints. A complaints register was in place.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Agape Care Warkworth Limited is the governing body and is responsible for the services provided. There is a business plan and quality and risk management systems for Leigh Road Cottage and documented scope, direction, goals, values, and a mission statement were reviewed. Systems are in place for monitoring the services provided including regular discussions between the facility manager and owner/manager.

The facility is managed by a facility manager with aged care experience who has been in this position for nine months. The owner/manager who is a registered nurse has overview, and with the registered nurses, is responsible for the clinical services in the facility.

There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Staff meetings are held on a regular basis.

There are policies and procedures on human resources management. An in-service education programme is provided.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on the District Health Board contract. A registered nurse and the facility manager are on call after hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in an integrated hard copy file.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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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 safely managed and administered by staff who are competent to do so.

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

Safe and appropriate environment

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

Residents' bedrooms provide single accommodation. Residents' rooms have adequate personal space provided. Lounges, dining areas and alcoves are available. External areas for sitting and shading is provided.

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

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

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard and identifies the use of enablers is voluntary and the least restrictive option to meet residents' need. There were no residents using restraints or enablers during the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by a registered nurse, 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	39	0	4	2	0	0
Criteria	0	84	0	5	3	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>Leigh Road Cottage 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>	FA	<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. Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent was defined and documented, as relevant, in the resident's record. All residents had an enduring power of attorney nominated. Staff were observed to gain consent for day to day care.</p>

<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>	<p>FA</p>	<p>During the admission process, residents and family members 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 spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</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. They were also frequently invited to share a meal with their relative at the home.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>The complaints policy, procedures and associated forms meet the requirements of Right 10 of the Code. A flow chart sets out the procedure for staff to follow. Information for residents and families forms part of the admission information.</p> <p>The complaints register showed eight complaints have been received for 2017. It was difficult to determine whether all complaints had been entered into the register because of the lack of documentation relating to the complaints entered. The register does not include dates to ensure compliance with Right 10 of the Code apart from resolution of the complaints.</p> <p>Although there were eight complaints entered in the register, there was no documentation to evidence compliance with Right 10 of the Code.</p> <p>The manager is responsible for complaints management and follow up. Staff interviewed confirmed an understanding of the complaints process and what actions are required.</p> <p>The owner/manager reported there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The resident and family members interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided. The Code is displayed in areas around the facility together with information on advocacy services, how to make a complaint and feedback forms.</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>The resident and families who were interviewed 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 to the extent possible by visits to the beach and other community activities (accompanied by a staff member), determining their own daily timetables. 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.</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 Cultural Policy-guidelines for the provision of culturally safe services to Maori residents, aims to show the provider's commitment to ensuring residents who identify as Maori have their needs met in a respectful way, acknowledging individual and cultural values and beliefs. The policy includes the Treaty of Waitangi and guidelines for awareness and implementation. Guidelines are clear for staff to follow. Related education is provided for staff two yearly. The policy states advisors are sought from the local DHB.</p> <p>An assessment form is completed for residents who identify as Maori and guidelines for staff when developing care plans. There are two residents who are Maori. The care plans of these two residents demonstrated consideration of their cultural needs.</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>The resident and families who were interviewed verified that they/their family member 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 (eg, a resident who is from the Cook Islands has cultural needs documented, and another resident for whom the Catholic faith is important has actions described on their care plan).</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>The resident and families who were 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. 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 frequent visits from the Geriatric Clinical Nurse Specialist for the area. The service makes good use of clinical study days provided by the local DHB for registered nurses. Resource books are available for reference and the internet is used to update knowledge when appropriate. Policies and procedures have reference to updated legislation and good practice, apart from the Health and Safety Policy. (Refer criterion 1.2.3.3). The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required, although on occasion they felt a higher level of treatment (e.g. acute Hospital) was sought when it may have been more appropriate, in his opinion, to seek advice from him first. He stated the staff were responsive to medical requests.</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>Family members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this</p>

		was rarely required due to all residents being able to speak English.
<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>Agape Care Warkworth Limited is responsible for the services provided. A business plan and a risk management plan were reviewed that included a philosophy, goals, purpose, objectives, mission statement and values. The owner/manager and facility manager(FM) stated the owner/manager spends at least three days a week at the facility and is involved in the management of the service. Both managers work closely together and reported they discuss a wide range of activities.</p> <p>The facility is managed by a facility manager (FM) who has been employed since September 2016 as the administrator. In December 2016 as the assistant manager and in March 2017 as the facility manager. The owner/manager is a registered nurse with aged care experience in dementia care and owns and operates another facility nearby that also specialises in dementia level care. There was evidence in the facility manager's file of appropriate ongoing education. The facility manager is supported by the owner/manager and two RNs. The owner/manager reported they were not sure if HealthCERT had been advised of the change of manager and reported advising HealthCERT during the audit of the appointment of the facility manager.</p> <p>The service's philosophy is in an understandable form and is available to residents and their family/representative or other services involved in referring residents to the service.</p> <p>On the first day of the audit there were 17 residents assessed as requiring dementia level care and one resident receiving rest home level care. The rest home resident has authorisation to stay by choice at the facility. The service has a contract with the DHB - 'Provision of Age Related Residential Care Service'.</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>	FA	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager be absent. The facility manager and the owner/manager deputise for each other. If the owner/manager is absent, the two RNs take overall responsibility for the clinical service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	PA Low	<p>A business, quality and risk management plan guides the quality programme and includes goals and objectives. Clinical indicators and</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>quality improvement data is recorded on various registers and forms and were reviewed as part of the audit. There was documented evidence that quality improvement data is being collected, collated, analysed and reported. Quality improvement data includes adverse event forms, internal audits, meeting minutes, satisfaction surveys, infection control surveillance and health and safety. Corrective action plans are being developed, implemented, monitored and signed off as being completed. Two monthly staff meetings include quality, health and safety, restraint and infection prevention and control. Meeting minutes are available for staff to read and sign off.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Not all the policy and procedures have been reviewed and updated. Policies and procedures are relevant to the scope and complexity of the service, apart from the medicines policy that has sections that are applicable to hospital level care. Policies reflect current accepted good practice, and reference legislative requirements apart from the health and safety policy. The resident admission policy includes a section on interRAI requirements. Staff confirmed they are advised of any updated policies and that they provide guidance for service delivery.</p> <p>A health and safety policy is available that includes a flow chart that guides staff. Actual and potential risks are identified associated with human resources management, legislative compliance, contractual risks and clinical risk. The hazard register identifies hazards and showed the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The owner/manager is the health and safety coordinator and is responsible for hazards. The owner/manager demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. They are reviewed by the RN and signed and closed out. The owner/manager reported they collate and analysis all incidents/accidents. The analysis form includes date, time, witnessed/unwitnessed, type, injury, injury site and cause. The originals are kept in the residents' files. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Collated</p>

		<p>results are used to improve service delivery.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The owner/manager and facility manager advised there has been an essential notification made to the Ministry of Health and DHB with Police involvement, since the previous audit. Review of documentation evidenced corrective actions have been developed and implemented. The owner/manager advised that the investigation remains open. The owner/manager advised HealthCERT of the change of manager (refer standard 1.2.1)</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>Policies and procedures relating to human resources management are in place. All staff files evidenced employment agreements, however, not all staff files reviewed evidenced all human resource processes have been followed.</p> <p>Apart from the facility manager, all staff files reviewed evidenced a completed orientation/induction programme with a check list completed. Orientation for staff covers the essential components of the service provided. New staff are 'buddied' to an experienced staff member as part of the orientation.</p> <p>The education programme is the responsibility of the owner/manager. In-service education is provided for staff including monthly education sessions, talks at handover, on-line learning and specific topics relating to resident's health status. Staff complete a New Zealand Qualification Authority education programme and the dementia specific modules. Staff interviewed stated they have completed the dementia specific modules and demonstrated a sound understanding of caring for residents with dementia. The owner/manager is the Careerforce assessor for the facility. Individual records of education including competencies are held on file and attendance records are maintained. The two RNs and the owner/manager are interRAI trained and have a current competency. The RN/infection control coordinator has not undertaken ongoing education specific to infection prevention and control.</p>

		Staff performance appraisals are not current. Annual practising certificates are current for the owner/manager, the two RNs and contractors who require them to practice. Staff confirmed they have completed an orientation, including competency assessments and attend ongoing education. Staff stated they thought their performance appraisals were out of date.
<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 rationale for determining staffing levels and skill mix to provide safe service delivery. The policy includes the staffing requirement in-line with the contract with the DHB. The rosters evidenced staffing levels exceed the minimum requirements. The owner/manager stated that due to the decrease in resident numbers, a review of staff hours is to be undertaken. The owner/manager reported the rosters are reviewed with the FM and dependency levels of residents and the physical environment are considered. The owner/manager who is a RN is at the facility at least three days per week as well as a RN on duty six days a week. There are three care staff on the morning and afternoon shifts and two care staff on the night shift. There are dedicated cleaners and laundry staff.</p> <p>The RN who is working on the day is rostered on call after hours with back up from the owner/manager. The FM is on call for non-clinical matters. Care staff interviewed reported adequate staff are available and that they can get through the work allocated to them. Families interviewed reported the number of staff on duty is adequate to provide their relative with safe care. Observations during this audit confirmed adequate staff cover is provided.</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.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during</p>

		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>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. This was sighted in all files reviewed. Prospective residents and their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p> <p>Leigh Road Cottage has contracts to provide dementia care. On the day of audit there were 17 residents receiving dementia care and one resident, who has been approved to remain there as a "right-of-life" receiving rest home care. Interview with this resident confirmed they was receiving appropriate care in the setting of their choosing. Notes confirmed that this is reviewed in conjunction with the resident each year.</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. 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 and this was seen to occur for a recently transferred client. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to a higher level of care demonstrated a planned and systematic transfer.</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 documented but contains sections that are not applicable to this dementia service, for example the standing orders section and the non-prescribed medicines section (refer to criterion 1.2.3.3).</p> <p>A safe system for medicine management using a blister packaged unit dosing system was observed on the day of audit. The staff observed</p>

		<p>demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines have been assessed as 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 medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</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 monthly but not weekly and six monthly stock checks.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There are no residents who self-administer medications at the time of audit, as appropriate to this type of service. There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The food service is provided on site by two cooks and a kitchen hand. The menu follows summer and winter patterns. Only one has been reviewed by a qualified dietitian.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service follows set policies that are reflective of food safety principles. The service is aware of the need to register a templated food control plan with the local authority by 31 March 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have 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</p>

		<p>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. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and satisfaction surveys. 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 NASC 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 NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>InterRAI is the primary assessment tool used to assess residents. This is supplemented by other validated nursing assessment tools, such as the 'mini mental state examination' (MMSE), pain scale, falls risk, skin integrity, and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of three trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and 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, medical and allied health professionals' notations clearly written,</p>

		informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. Care plans were well documented and included specific information pertinent to people with dementia including behaviour management plans.
<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 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, although the GP stated he would love to see more stability within the RN workforce. 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.</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 activities officer. Whilst the activities officer is providing a full and varied activities programme that is appropriate to the resident group, they do not have a formal qualification in diversional therapy (refer criterion 1.2.7.5).</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents confirmed they find the programme stimulating and fun. Family members interviewed spoke very highly of the activities programme.</p> <p>The outside environment provides easy access to outside areas that enable residents to come and go safely within the secure garden area (which is very large). There are seating arrangements and different areas of focus including vegetable gardens, farm animals (chooks) and</p>

		<p>residents who were admitted with their own animals (five small dogs in total) and are encouraged and supported to continue to care for their pets</p> <p>Activities are offered at times when residents are most physically active and/or restless. This includes morning walks to the beach, including on occasion, time for boogie boarding, dog care throughout the day and evening, music, quoits, and happy hour. The registered nurses and caregivers interviewed stated that they have access to activities to support residents after hours and on the weekends.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<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 three wounds currently being managed. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may use another medical practitioner, but in reality due to the remote location of the service, all residents use the 'house doctor'. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	FA	<p>There are documented policies and processes for the management of waste and hazardous substances that comply with legislation. Incidents</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>are reported in a timely manner. Safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current.</p> <p>There was protective clothing and equipment in the laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances. Education has been provided for the safe use of chemicals. The cleaner was unavailable for interview.</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>A current building warrant of fitness is displayed that expires on the 22 February 2018. There is a proactive and reactive maintenance programme in place. Staff record issues in a maintenance book and corrective actions are completed and closed out. Documentation, interviews and observation confirmed this. The testing and tagging of equipment and calibration of bio medical equipment was current.</p> <p>Recordings of hot water temperatures show temperatures at resident outlets are consistently 45 degrees Celsius or below.</p> <p>Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use any equipment.</p> <p>Families and staff confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. There is good space in the facility and residents were observed moving freely around and families reported the accommodation meets their relative's needs.</p> <p>The interior of the facility over all is adequately maintained. Observation evidenced the bedrooms are being repainted as residents vacate them. The shower floor in the Takahe wing slopes towards the door instead of the waste outlet, resulting in damage to the door and floor. The gradient of the internal ramp leading from the Hi Hi wing lounge to the bedrooms is very steep.</p> <p>There are external areas of the facility that require painting as the wood underneath is exposed, the iron on the roof has rust showing through and there is moss growing on the south facing walls. The flower gardens</p>

		<p>are in need of maintenance.</p> <p>The facility is built on the side of a hill, with a secure fence surrounding the entire property. There is a flat area covered in concrete where several raised vegetable gardens are situated and residents can frequent the area. The FM stated the residents do not wander outside alone and go walking with a staff member. The retaining wall near the raised gardens is about 1.5 metres high. This area is not safe as the top of the retaining wall can be easily accessed by residents. The path leading from the Kereru wing to the exterior is on a slope, the concrete is broken in parts and uneven.</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 is a mix of bedrooms with a wash hand basin and toilet and wash hand basin. There are an adequate number of accessible showers, toilets and hand basins for residents. Toilets and showers are of an appropriate design. (Refer criterion 1.4.2.4) The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned.</p> <p>Communal toilets and showers have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is a mix of bedroom sizes. Bedrooms have personal space provided for residents and staff to move safely around. The resident and families spoke positively about their or their relative's accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is adequate room in the facility to store mobility aids including walkers and walking sticks.</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>Areas are provided for residents to frequent for activities, dining, relaxing and for privacy. The resident, families and staff confirmed, and observation evidenced these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is washed on site. Families reported the laundry is managed well and residents' clothes are returned in a timely manner.</p> <p>The facility is cleaned to an adequate standard. A dedicated cleaner is employed for 25 hours, Monday to Friday. The cleaner has received appropriate education. The resident and families stated the facility is kept clean. The latest satisfaction survey confirmed this. Chemicals are stored securely and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The emergency management plan complies with applicable statutory requirements. Documentation confirmed the fire evacuation scheme is approved and six-monthly fire drills are completed. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted, and equipment has been checked within required timeframes.</p> <p>All staff have a current first aid certificate.</p> <p>A civil defence plan is in place. There are adequate supplies of food, water, blankets, cell phones and gas BBQs. The contents are checked six monthly by the FM. The facility has a petrol generator for emergencies.</p> <p>There are call bells to alert staff. Staff reported that residents rarely use the call bells. The resident and families reported staff respond promptly to call bells.</p> <p>Contractors must sign in and out of the facility. The owner/manager reported staff lock the external doors at 7pm. Staff complete a physical check at handover and hourly thereafter. A second gate has been installed at the front entrance and all gates have key pad security. The owner/manager reported security cameras have been installed since the incident in November 2017 and that the one rest home resident and families were advised of this. The resident and families confirmed this and were positive about the installation.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident and</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>family feedback in relation to heating and ventilation. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. A mix of wall heaters with fans and flat wall heaters heat the bedrooms and wall heaters in the common areas. All resident areas are provided with natural light. The resident and families reported the temperature is always comfortable.</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 developed in conjunction with a company with specialist infection prevention and control expertise. The infection control programme is reviewed annually.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the manager, and tabled at the two-monthly staff meetings, which include quality, health and safety, restraint and infection prevention and control.</p> <p>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 only recently been confirmed in to her role. The IPC coordinator would benefit from further training specific to infection prevention and control to better support her in this role (refer criterion 1.2.7.5). Additional support and information is accessed from the infection control team at the DHB, the community laboratory, and the GP 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, and these were sighted.</p>
<p>Standard 3.3: Policies and procedures</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>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>		<p>practice. Policies were last reviewed in 2013 (refer CAR at criterion 1.2.3.3) 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 the 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.</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, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and infestations such as scabies. The IPC coordinator reviews all reported infections and these were 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.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. There are currently no residents using restraints or enablers as evidenced by observation, documentation and interviews. The owner/manager reported the facility has not used restraint since ownership of the facility. The FM reported restraint has not been used for many years. There is a restraint register should restraint be required. Care staff demonstrated a good understanding of the difference between restraint and enablers.</p>

		Education related to restraint/enablers and challenging behaviours is a mandatory attendance topic. The restraint coordinator is the owner/manager and any challenging behaviours is an agenda item at the two monthly staff meetings.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>The policy and procedures meet Right 10 of the Code and includes the process relating to making a complaint. A booklet titled 'Information for Residents and Family' on complaints is included as part of the admission information. Staff and family demonstrated an awareness of the complaints process. There was no documentation available relating to any of the complaints received.</p> <p>A complaints register evidenced eight complaints have been received for 2017. It was difficult to ascertain whether the register included all complaints received as only complaints for 2017 were entered. The register includes sections on the complainant, the complaint, action and date the complaint was resolved. The register does not have sections for</p>	<p>There was no written documentation available for any of the complaints entered in the complaints register to evidence compliance with Right 10 of the Code. The register does not provide for entering timeframes relating to responding to complainants.</p>	<p>Provide documented evidence that all complaints received meet Right 10 of the Code.</p> <p>90 days</p>

		entering other dates to meet Right 10 of the Code		
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	<p>Approximately a quarter of the policies and procedures have been reviewed and updated. A number have not been reviewed since 2011 and 2013. The owner/manager reported they are currently reviewing and updating all policies. Policies and procedures reviewed are relevant to the scope and complexity of the service, apart from the medicines policy that has sections that are applicable to hospital level care. Policies reflect current accepted good practice, and reference legislative requirements apart from the health and safety policy that does not reflect the current legislation.</p>	<p>Approximately three quarters of the policies and procedures have not been reviewed and updated. The medicine policy has sections that are not applicable to dementia level care.</p>	<p>All policies and procedures are reviewed and updated, including reference to current legislation, as per the timeframe set out in the policy.</p> <p>180 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Moderate	<p>All staff files reviewed evidenced employment agreements, confidentiality agreements, house rules and codes of practice. However, not all staff files evidenced position descriptions, reference checks, police vetting and current performance appraisals. Of the five files reviewed, there was no evidence of police vetting; two staff members were new and performance appraisals were not due; three files had reference checks, and three files had position descriptions.</p>	<p>(i) There was no evidence in the five files of police checking; (ii) three files had no current performance appraisals (the other two staff member are recently employed and therefore not due); (iii) there was no evidence in two files of reference checking; (iv) there was no evidence in two files of position descriptions.</p>	<p>Human resources processes are to be completed for all staff including police checking, reference checks, position descriptions and performance appraisals.</p> <p>60 days</p>
<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</p>	PA Low	<p>The owner/manager is responsible for developing and implementing the education programme. Monthly education includes on line learning and in-house sessions. Staff records evidenced of the</p>	<p>The RN/ infection control coordinator has not undertaken ongoing education specific to infection prevention and control.</p> <p>The Activities Officer has not</p>	<p>Ensure training is provided to the RN to assist her in her role as ICN.</p> <p>Ensure the Activities Officer has the knowledge</p>

<p>services to consumers.</p>		<p>16 care staff, 11 have completed the New Zealand Qualification Authority education programme (ACE) and the dementia specific modules. The owner/manager reported three new staff are currently completing the dementia specific modules and two new staff are enrolled to start. Staff interviewed stated they have completed the dementia specific modules. Staff demonstrated a sound understanding of caring for residents with dementia. The owner/manager is the Careerforce assessor for the facility. The activities officer is currently completing the certificate in 'Understanding Dementia' from the University of Tasmania. The education programme for the facility also includes sessions on dementia.</p> <p>Individual records of education including competencies are held on staff files, in the education folder and electronically. Attendance records are maintained and show good attendance by staff.</p> <p>One of the two RNs assumes the role of the Infection Control Nurse (ICN) and a role description is documented (although this is dated 2013 and has not been reviewed). The RN has completed training in relation to hand washing but not specifically to her role as ICN. The ICN demonstrated good understanding of infection prevention and control principles.</p> <p>The Activities Officer, on interview was found to be deeply committed to her role and thoroughly enjoying it; however, she</p>	<p>received training to support her to assess, implement and evaluate the activities programme.</p>	<p>and skills to ensure she can provide assessment, implementation and evaluation of the activities programme.</p> <p>180 days</p>
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		does not have a formal qualification that demonstrates she is skilled in and accountable for the assessment, implementation and evaluation of the activities programme, as per contractual requirements.		
<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>	PA Low	<p>Medicines are stored in a locked medication cupboard, which is only used for this purpose. The cupboard is large enough to accommodate the medication trollies, shelving, a medication-only fridge and a combination-secure controlled drug safe. The medication cupboard was clean and well ordered. A controlled drug register is maintained for a very small number of controlled drugs and each time a controlled medication is administered, a record of its administration is entered appropriately. Controlled drugs are counted each month and a record maintained. However, this does not meet the requirement of a weekly count. The required six-monthly stocktake has not been undertaken in the last year.</p>	<p>An 'audit' (count) of the controlled drugs is conducted monthly, rather than the required weekly. There has not been a required six-monthly controlled drug stocktake in the last year.</p>	<p>Ensure a count of controlled drugs is undertaken weekly and that a controlled drug stock take is undertaken six monthly.</p> <p>180 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	<p>A varied four-weekly cyclical menu is developed for winter and a separate one for summer. The winter menu has been reviewed by a qualified dietitian within the last six months. Recommendations made at that time have reportedly been implemented. The summer menu is now in use and this has not been reviewed by a qualified dietitian although this is planned to occur imminently. The menu shows a varied diet that includes</p>	<p>The summer menu is now in use and this has not been reviewed by a qualified dietitian.</p>	<p>Ensure the summer menu is reviewed by a qualified dietitian.</p> <p>180 days</p>

		breakfast, lunch, dinner, morning tea, afternoon tea and supper options. A plate of sandwiches and other snacks is available for residents 24-hours per day.		
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA</p> <p>Moderate</p>	<p>The facility overall is appropriate to caring for residents with dementia. It is spacious and there is lots of room for residents to walk around independently. Hand rails are situated along the passage ways. The Takahe wing shower has a floor that has been built with the slope going towards the door instead of the waste outlet. On observation, the entire floor was wet and the bottom of the door damaged which has become an infection control issue. The water may have also seeped into the walls.</p> <p>The internal ramp leading from the Hi Hi wing lounge to the bedrooms is very steep and exceeds the recommended gradient of 1 in 12 stipulated in NZ Standards 4121:2001 'Design for Access and Mobility- Building and Associated Facilities'. The auditors found extra care is required to negotiate the ramp, even with hand rails for support. The FM reported the ramp has been there for years and to their knowledge no residents have fallen to date. The FM reported they manage the situation by only having residents in the wing who have stable mobility. It would be beneficial for the organisation to document these actions as a management plan.</p> <p>External areas of the facility need painting as the wood underneath is</p>	<p>(i)The shower floor in the Takahe wing slopes towards to the door, and as a result water is damaging the door and potentially the floor and walls.</p> <p>(ii)The flower gardens surrounding the facility are overgrown and need weeding.</p> <p>(iii) External areas of the building have paint worn off, the roofing is showing rust and there is moss on the south walls.</p>	<p>(i)Provide a timeframe for replacing the shower door and rectifying the way the water flows. (ii)Weed and maintain the flower gardens. (iii)Ensure the exterior of the facility is maintained.</p> <p>90 days</p>

		exposed to the elements. The long run iron on the roof has rust showing though in areas. Moss is growing on the south facing walls of the facility. The flower gardens look neglected and weeds have taken over.		
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>PA</p> <p>Moderate</p>	<p>External areas are easily assessed. However, the exterior is mostly slopping apart from an area where the raised vegetable gardens are situated. The manager reported residents tend to stay inside or sit just outside the front door and that staff walk with residents if they want to venture further away. The auditors observed this. A secure fence surrounds the entire property and the gates leading beyond are secure with key pads. There is seating and shade for residents to frequent.</p> <p>The retaining wall near the raised gardens was built by the previous owners and is approximately 1.5 metres high. Residents can easily walk along the top of the retaining wall and fall on to the concrete below even though the current owner has put up a hazard sign and installed a wooden plank to deter residents. The plank is low and the situation remains unsafe.</p> <p>The path leading from the Kereru wing to the exterior is on a slope, the concrete is broken in parts and uneven.</p>	<p>(i)The concrete path leading from Hi Hi wing to the outside is broken, uneven and sloping.</p> <p>(ii)The retaining wall near the raised gardens is approximately 1.5 metres high and can easily be accessed by residents, who could walk along the top of the wall and fall on to the concrete below.</p>	<p>(i)Provide a timeframe for repair of the concrete path</p> <p>(ii)Provide a timeframe for making the area leading to the top of the retaining wall safe.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.