

Ellora Enterprises Limited - Sheaffs Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Ellora Enterprises Limited
Premises audited:	Sheaffs Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 December 2017 End date: 14 December 2017
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	28

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

This surveillance audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. Sheaffs Rest Home can provide care for up to 29 residents requiring rest home level of care.

The audit process included the review of policies, procedures, residents and staff files, observations and interviews with the general practitioner, residents, family, manager and staff.

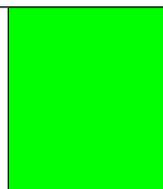
The manager is responsible for the overall management of the facility with a registered nurse providing clinical oversight.

Improvements required at the previous audit have been met. These include improvements in relation to completion of incident forms; clear interventions documented in care plans when challenging behaviour is identified; training for staff; transcribing of medication orders; personal protective equipment; training for the infection control coordinator.

Improvements identified at this audit are required to food services; stock takes of controlled drugs; medication competencies for the registered nurse; criminal vetting and calibration of medical equipment.

Consumer rights

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



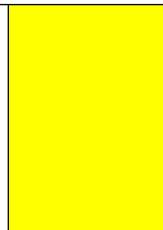
Standards applicable to this service fully attained.

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

Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. A complaints register is maintained.

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 low risk.

The manager (owner of the service) provides operational management with support from a registered nurse.

There is a documented quality and risk management system that supports the provision of service delivery. Policies are in place and quality and risk performance is reported and discussed at the staff meeting. The quality and risk management programme includes analysis and discussion of incidents, complaints, surveillance of infections and review of service delivery with an internal audit schedule implemented. Corrective action plans are documented with evidence of resolution of issues.

There are human resource policies documented around selection of staff, orientation and training. Staff, residents and family confirm that staffing levels are adequate, and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

Continuum of service delivery

<p>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.</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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Service provision is coordinated to promote continuity of service delivery. The residents interviewed confirm that they have input into care planning. Resident care planning is changed according to the needs or when progress is different from expected. The service uses short-term care plans for acute problems.

The residents interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis with a diversional therapist leading the programme.

There is an electronic medication system in place. The registered nurse or caregivers administer medication. Medication charts have photo identification and allergy status noted.

Food, fluid, and nutritional needs of residents are provided by cooks with additional requirements provided as per individual need. A dietician has reviewed the menu.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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All building and plant is maintained. Equipment is tested annually. Personal protective equipment is available and observed to be used when required. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Residents have access to outdoor areas that are safe.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There are no residents using enablers or requiring restraint on the day of 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.

The policies and procedures guide staff in areas of infection control practice. The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided with a low rate of infections. The infection control coordinator has completed training around infection control in the past year.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	1	1	2	0	0
Criteria	0	40	1	2	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and procedure refer to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes timeframes for responding to a complaint. Complaint forms are available in the facility. Residents and family interviewed know how to make a complaint but all state that they do not need to as they feel they can raise any issue or concern with the manager or registered nurse. They state that they are heard with issues addressed as soon as they are raised.</p> <p>There is a complaint's register in place with documentation retained of any complaint. One complaint was reviewed, and this confirms that the policy has been implemented with the complaint addressed in a timely manner. The complainant signs to state that they are satisfied with the outcome of the complaint.</p> <p>The manager confirms that there have not been any complaints from any external authorities since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>The service has policies covering communication, access to interpreters and the manager and registered nurse maintain an open-door policy that encourages residents and family to talk with them if there are issues. Information is provided in a manner that the resident can understand as confirmed</p>

<p>provide an environment conducive to effective communication.</p>		<p>by residents and family interviewed. Resident meetings are held three to six weekly and family are encouraged to attend.</p> <p>The incident and accident forms include an area to document if family have been contacted with all reviewed indicating that family are contacted when an incident has occurred. Open disclosure is practised and documented when family are contacted as per policy.</p> <p>Residents and relatives interviewed confirm that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirm that they are advised if there is a change in their family member's health status. The general practitioner (GP) interviewed reports satisfaction with communication by staff</p> <p>There are no residents requiring access to interpreting services currently noting that te reo Māori is used for Māori residents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Sheaffs Rest Home provides rest home level care for up to 29 residents. On the day of the audit, there were 28 residents, all under the aged residential care contract. The owner manages the service and is referred to as the manager. She is supported by an enrolled nurse and a registered nurse.</p> <p>The goals and direction of the service are documented in the business plan and quality plan.</p> <p>The owner/manager has maintained eight hours' professional development activities related to managing a rest home.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a documented quality plan within the business plan which is reviewed annually. There is a risk management plan documented. Goals are documented in both plans and reviewed at meetings. The enrolled nurse and the manager lead the quality and risk management programme.</p> <p>The service implements organisational policies and procedures to support service delivery. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, contracts, and evidenced-based best practice guidelines. New policies and procedures reference interRAI; pressure injuries and the changes in health and safety legislation. Outdated policies are archived on site. There is a formal document control process in place. Documents are reviewed two yearly or earlier when required. All policies are reviewed on an ongoing basis by an external consultant.</p> <p>The quality and risk management systems include quality improvement; risk and hazard management; complaints management; management of incidents and accidents; health and safety management; infection prevention and control and review of any use of restraint. Residents are asked to complete satisfaction survey six weeks after entering the service. Residents and family are offered the</p>

		<p>opportunity to complete a satisfaction survey with last completed in April 2017. Respondents documented a high level of satisfaction with service delivery.</p> <p>Quality improvement data including review of hazards are analysed at the staff meetings held six weekly. All aspects of the quality and risk management programme are discussed. Graphs are used to review trends annually.</p> <p>An internal audit schedule is implemented. Corrective action plans are documented and there is evidence of resolution of issues as required.</p> <p>There are three to six weekly resident meetings. Family can attend. Residents interviewed state that they can hold a resident meeting whenever they wish to discuss an issue and find that these are very valuable.</p> <p>Health and safety policies and procedures are documented along with a hazard management programme. These policies have been revised since the changes in health and safety legislation. There is evidence of hazard identification forms being completed when a hazard is identified. Hazards are assessed then eliminated, minimised or isolated. Health and safety matters are discussed at the staff meeting.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The manager and enrolled nurse are aware of situations where there is a need to notify statutory authorities and where HealthCERT would need to be notified of a Section 31 adverse event. There have been no such events since the previous audit.</p> <p>Staff document adverse, unplanned, or untoward events to identify opportunities to improve service delivery, and to identify and manage risk. A review of incidents and accidents since the previous audit as documented in the staff meeting minutes indicates that there is a low number of adverse events. Neurological observations are taken for a sustained period of time if there is a head injury as a result of a fall or an unwitnessed fall and the resident is not able to describe what happened.</p> <p>There are currently no residents with challenging behaviour in the service. The manager and enrolled nurse can describe documentation of an incident form should there be an incident of challenging behaviour. Resident records were reviewed to identify incidents as documented in the progress notes and a review of incident forms confirmed that these were always documented as per policy. Any issues are also referred to in the care plans. The improvements around documentation of incident forms and the subsequent link to care planning required at the previous audit have been met.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>PA</p>	<p>There are policies and procedures in relation to human resources management. A review of staff</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>Negligible</p>	<p>records indicates that there is recruitment documentation including reference checks; an employment agreement signed; a job description and evidence of qualifications and orientation records. Criminal vetting of a potential staff member occurs if the person is not known to the manager and an improvement is required to ensure that all staff are criminal vetted.</p> <p>An annual training plan is implemented with a log of training retained for each staff member. Required training has been provided. The registered nurse has completed training for interRAI. Staff files sampled contained a current annual performance appraisal. Residents and families state that staff are knowledgeable and skilled. The improvement required at the previous audit around staff training has been met. Staff have completed training around infection control; chemical safety; skin care and behaviours that challenge in the last year.</p> <p>Staff are required to have an annual performance appraisal and these are completed as per policy. Professional qualifications are kept on file. The registered nurses, enrolled nurse, pharmacists, doctor and other visiting health professionals have a current annual practicing certificate on file.</p> <p>There is an annual in-service education programme, which includes mandatory training for all staff attending the staff meeting. Attendance is recorded. Training includes key aspects of service delivery and staff interviewed state that it is relevant to them and meets their needs.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a staffing policy with rosters detailing which staff members are on duty. Staff work 10 hour shifts with staggered starting times so that there is extra support for residents when needed most. The manager lives onsite and is on call when required. The registered nurse and enrolled nurse work four days on and four days off to ensure that there is always clinical support each day of the week. The registered nurse and enrolled nurse are on call and the enrolled nurse can contact the registered nurse if required when they are on call.</p> <p>The caregivers interviewed understand when to call emergency services and when to call on call staff.</p> <p>There are a total of 20 staff employed including the manager; a registered nurse; an enrolled nurse, a diversional therapist; caregivers and cooks. Staff complete laundry and cleaning and state that there are sufficient numbers of staff on duty at any time to ensure that residents can be cared for as per their individual needs. Staff are replaced when on leave as confirmed through a review of the rosters.</p> <p>Residents state that there are sufficient staff to support them.</p>
<p>Standard 1.3.12: Medicine Management</p>	<p>PA Moderate</p>	<p>A medication policy documented is reflective of current safe practice guidelines. There is an electronic medication system in place. Staff and the general practitioner state that medication errors have</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>decreased since the introduction of the system.</p> <p>The policy identifies that staff who administer medicines must be competent. Caregivers who administer medications have completed medication competencies for 2017 however the registered nurse does not have a current medication competency and an improvement is required. The staff member observed administering the lunchtime medication complies with regulation requirements.</p> <p>Medicines are kept in a locked cupboard in the office. The medications that require to be stored in the fridge are in the kitchen fridge on a separate shelf in a sealed container (refer 1.3.13).</p> <p>Controlled drugs are kept in a secure place as per policy (refer 1.3.13). Controlled drugs are prescribed and administered as per policy and prescription however an improvement is required to completion of stock takes of controlled drugs.</p> <p>As required medications are charted with documentation of indications for use and maximum dose per hour.</p> <p>The medication policy provides instructions around self-administration of medication. One resident is self-administering medication with a competency completed by the general practitioner confirming that the resident can self-administer medication as per the prescription. The medication is in the resident's room in a locked space. Staff describe checking daily that the resident has taken their medication.</p> <p>Resident records reviewed evidenced photographic identification. The photograph in the resident file includes the date of the photograph being taken. Any allergies or sensitivities are documented on the medical notes and the resident's medication record in One Chart. All medications are prescribed individually and signed and dated by the general practitioner through their electronic login details. The registered nurse checks the medication packs when received from the pharmacy.</p> <p>One Chart has meant that any resident using warfarin has instructions entered onto their prescription by the general practitioner. This has meant that any transcribing of new instructions has ceased improvement required at the previous audit has been met.</p> <p>All medications are current with expiry dates checked and any expired medication returned to the pharmacy when identified. The service used to have stock drugs kept however a change in pharmacy to a local provider has meant that this is no longer required. Stock drugs on site were returned to the service on the day of audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids</p>	<p>PA Moderate</p>	<p>The rest home uses the summer/winter seasonal menu which has been reviewed by a dietitian in December 2015.</p> <p>An individual dietary assessment (nutritional status) is completed on admission for all residents which</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>identifies individual needs, allergies and preferences. The dietary forms are updated if there are changes for the resident however these are not updated as part of the six-monthly reassessment and review of care plans and an improvement is required.</p> <p>Morning and afternoon teas are prepared in the kitchen by cooks. Residents are weighed on admission and monthly and evidence is seen of a process to monitor unexplained weight loss or gain. This includes contacting the resident's general practitioner and notifying the kitchen of extra dietary requirements.</p> <p>The service is managed by cooks over seven days however documentation that evidences food safety training for these staff was not able to be sighted and an improvement is required.</p> <p>Special diets can be arranged, for example puree, fortified fluids, vegetarian diets or gluten free diets. Residents interviewed praised the food service.</p> <p>Fridge and freezer temperatures are taken two times a week however an improvement is required to ensure that these are within normal range and that all fridges are checked. Food is not checked to ensure that it is completely cooked through and an improvement is required.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents' care plans evidence interventions, desired outcomes or goals of each resident. The general practitioner documents notes that confirms that reviews have occurred three monthly or according to timeframes documented. Residents interviewed confirm that their current care and treatment meets their needs.</p> <p>The registered nurse or enrolled nurse documents any review of residents with the staff confirming that they are familiar with the current interventions of the resident.</p> <p>Short term care plans are developed, when required and signed off by the registered nurse. They record the detail of information required. The registered nurse signs these off as completed when the issue is resolved. Short-term care plans were documented for such issues as infections and anxiety.</p> <p>The registered nurse monitors to ensure all cares have been completed in a timely manner. Vital recordings are taken as per resident need and at least monthly. A review of the forms with attention to specific needs of the resident as identified through interview and through the care plan indicate that residents are monitored as per their individual requirements.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the</p>	<p>FA</p>	<p>The diversional therapist has an allocation of eight hours a day for four days per week. The programme is planned with the residents having input informally and through the resident meetings. The activities programme is displayed on white boards in the main areas of the service. Individual</p>

<p>service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>assessments, plans and reviews are documented by the diversional therapist. The diversional therapist completes a daily attendance sheet for each resident. Assessments and plans with evidence of review were sighted in all resident files reviewed. The diversional therapist has input into the interRAI assessment.</p> <p>The diversional therapist keeps the resident notes around activities in a separate folder so that they can complete documentation in a timely manner. The notes are integrated when a page is completed.</p> <p>Regular exercises are provided, and the programme includes intellectual activities, spiritual activities, input from external agencies and supported ordinary unplanned/spontaneous activities including celebrations. The programme reviewed is implemented ensuring the strengths, skills and interests of residents are maintained. Residents are encouraged to maintain activities in the community. The chaplain interviewed confirms that the programme includes a focus on spiritual and pastoral care.</p> <p>There is an individualised approach to activities that encourages independence of residents. The diversional therapist encourages a lot of engagement with the community including the marae and the general practitioner describes seeing the younger residents actively engaged in community events.</p> <p>Residents report they are happy with the activities provided.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluation of care plans are documented within timeframes documented in policy. Residents confirm their participation in care plan evaluations.</p> <p>The residents' progress records are entered in at each shift and as changes occur. When resident's progress is different from expected, the enrolled nurse states that they contact the general practitioner. The registered nurse writes comments in the resident file on the days they are on site and the enrolled nurse writes in the progress notes if there are changes in the resident.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</p> <p>Review of care plans occurs six monthly and as changes occur (refer 1.3.13).</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste,</p>	<p>FA</p>	<p>There are policies in place for waste management, waste disposal for general waste and medical waste management. All chemicals are labelled with manufacturer labels. Chemical product use and safety data sheets are available. Chemicals are stored safely. Gloves and other personal protective equipment is available in key areas including the laundry. The improvement required at the previous audit has been met with face protection available in the laundry.</p>

infectious or hazardous substances, generated during service delivery.		
<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>The service displays a current building warrant of fitness that expires in 2018. A reactive and planned maintenance programme is in place.</p> <p>Hot water temperature checks are monitored and recorded monthly. An external contractor has completed testing and tagging of electrical equipment. Annual calibration of medical equipment has not been completed and an improvement is required.</p> <p>Residents were observed to safely mobilise throughout the facility with easy access to communal areas. The external area is well maintained with safe paving, outdoor shaded seating and gardens. Interviews with staff confirmed there was adequate equipment to provide safe and timely care.</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>	FA	<p>The staff orientation programme includes infection control education. Education is provided to residents during daily support with all residents interviewed able to describe infection prevention practice that is safe and suitable for the setting. Staff have completed training around infection control in 2017 and the enrolled nurse and registered nurse (infection control coordinators) have attended an infection control training module through the District Health Board in 2017. The improvement required at the previous audit has been met.</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>	FA	<p>The infection control coordinators (registered nurse and enrolled nurse) are responsible for the surveillance programme. Surveillance data relating to number and type of infections is recorded in the staff meeting minutes and there is evidence the data is being analysed and discussed.</p> <p>Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events with these retained in individual resident files. Staff report they are made aware of any infections of individual residents by way of feedback from the registered nurse or enrolled nurse; through verbal and written handovers and through documentation in progress notes.</p> <p>A review of the data over the past year indicates that there have been a small number of infections in 2017.</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>Policies and procedures around restraint minimisation and use of enablers are documented and there are links with the policy for managing challenging behaviour. These are accessible to guide staff actions related to restraint and enabler use.</p> <p>Enablers are only used for safety reasons. Staff interviewed understand that the use of enablers is to be a voluntary and the least restrictive means to meet the needs of residents with the intention and/or maintaining of a resident's independence. There is no evidence of restraint or enablers being in use at this facility.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Negligible	Staff have relevant documentation on their staff file. The manager states that criminal vetting is completed for staff who are unknown to the manager at the time of employment. They state that Whakatane is a small town and therefore criminal vetting and checking of references is not completed for staff who are known to the manager. Three of the files reviewed included documentation to confirm criminal vetting. One new staff member has a reference check and the manager states that these are now completed for new staff.	Two of the staff files reviewed do not have documentation of evidence of criminal vetting.	Ensure that each staff member is criminally vetted prior to appointment. 180 days
Criterion 1.3.12.3 Service providers responsible for	PA Moderate	Staff are expected to complete annual medication competencies. All caregivers and the enrolled nurse who administer medications have completed these competencies in a timely manner.	The registered nurse has not completed a medication	Ensure that any staff who administer medication

medicine management are competent to perform the function for each stage they manage.			competency to date.	have a competency completed annually. 90 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	Controlled drugs are kept in a locked safe in the locked cupboard. The registered nurse was able to describe the process for management of controlled drugs that included these being checked by two staff when being administered. Documentation reviewed confirms that this the controlled drug register is documented as per protocol when medication is administered with two staff signing the One Chart electronic administration record. The balance of controlled drugs checked during the audit matches records documented in the controlled drug register. An improvement is required to completion of stock takes of controlled drugs.	Stock takes of controlled drugs have not been completed in the last three months as per policy.	Complete stock takes of controlled drugs as per policy. 90 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Moderate	<p>The cook takes the fridge and freezer temperatures. Recordings of the temperature of the fridge in the kitchen confirm that it is in normal range. One fridge is not checked for temperature range. The freezer temperature is recorded at times as being outside the normal range. The cook states that it is probably because the freezer door has been opened and shut prior to the temperature being taken. The thermometer reading on the day of the audit confirms that the temperature was within normal range on that day.</p> <p>The cook states that in the past cooked food was checked to ensure that it was thoroughly cooked however this has not been completed for some time.</p> <p>A review of staff training confirmed that the cooks have completed training around infection control. Records of food safety training for the cooks was not able to be sighted and an improvement is required.</p> <p>A dietary assessment is completed initially when the resident enters the service, and this is then kept in the kitchen. This is updated as changes occur however it is not reviewed as part of the six-monthly reassessment and review of the care</p>	<p>i) One fridge is not checked to ensure that the temperature is within normal range.</p> <p>ii) Recordings of the freezer temperature do not confirm that the temperature is</p>	<p>Ensure that all fridges are checked to ensure that the temperature is within normal range.</p> <p>Ensure that the temperature of the freezer is within normal range.</p>

		plan.	<p>within normal range at all times.</p> <p>iii) Temperatures of cooked food are not taken.</p> <p>iv) Confirmation of food safety training for the cooks was not able to be sighted on the day of audit.</p> <p>v) The resident's dietary assessment is not reviewed six monthly as part of the reassessment and review of care plans.</p>	<p>Ensure that temperatures of hot food are taken to check that food is thoroughly cooked through.</p> <p>Ensure that each cook completes food safety training.</p> <p>Review the dietary assessments as part of the review of care plans at six monthly intervals.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>Medical equipment has been checked in the past on an annual basis however the contracted company has changed, and checking has not occurred this year as planned.</p>	<p>Medical equipment has not been calibrated in the past 12 months.</p>	<p>Ensure that medical equipment is calibrated annually as planned.</p>

				90 days
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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.