

Heritage Lifecare Limited - Waiapu House

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:	Heritage Lifecare Limited	
Premises audited:	Waiapu House	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 11 January 2018	End date: 12 January 2018
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	66	

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
	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
	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

Waiapu House Lifecare provides rest home and hospital level care for up to 74 residents. The service is operated by Heritage Lifecare Limited (HLL) and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service`s contract with the district health board. The audit process included review of policies and procedures, review of residents` and staff records, observations and interviews with residents, family members, management, staff and contracted allied health providers. A general practitioner was not available for interview.

This audit has resulted in a continuous improvement for infection prevention and control. There were one area identified as requiring improvement relating to staff members name being identifiable in progress notes.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents 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 and care provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. There was no evidence of abuse, neglect or discrimination.

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 and act on any advance directives.

Residents who identify as Māori, or other cultures, have their needs met in a manner that respects their individual cultural values and beliefs.

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

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

Organisational management

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

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

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

There was no information of a personal nature on display. There is secure storage of records.

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.		Standards applicable to this service fully attained.
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Entry to the service is clearly defined in policies. If a potential resident is declined entry to the service, this is recorded and the referrer informed.

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring hospital and rest home level care. Staff are qualified to perform their roles and deliver all aspects of service delivery. All residents are assessed on admission and assessment details are retained in the individual resident's record.

The residents' lifestyle plans document the needs, outcomes and/or goals and these are reviewed at least six monthly, or more often as required. The service uses a mix of electronic and paper based assessment tools. The residents, and where appropriate the family/whanau, are involved in the lifestyle planning and review.

The activities available are appropriate for residents requiring hospital and rest home level care, including the needs of younger people under the age of 65. The programme is a strength of the service and meets the interests of the residents.

The service has implemented a web based medication management system that complies with current legislation. Staff who assist in medication management are assessed as competent to perform their role. There is a process in place for residents to safely self-administer their medications.

The menu plan has been developed for Heritage Lifecare and has been reviewed by a dietitian. Each resident is assessed on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. The kitchen has registered a food safety plan.

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.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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

Infection prevention and control

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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There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually. Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff. The GP, or other specialised input, is sought as required.

Infection control education is provided by the infection control coordinator or external specialists, who have current knowledge of best practice. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	0	1	0	0	0
Criteria	1	99	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the in-service education programmes. Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents reported that they understand their rights. The relatives reported that residents are treated with respect and dignity.</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</p>	FA	<p>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where applicable, this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. An advance directive and advance care</p>

<p>informed consent.</p>		<p>plan are used to enable residents to choose and make decisions related to end of life care. The files reviewed have signed advance care plans that identify residents' wishes and meet legislative requirements</p> <p>Residents and family/whanau (where appropriate) are included in care decisions.</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>Advocacy information is available in brochure format at the entrance to the facility. Residents and family/whanau are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The staff interviewed reported knowledge of residents' rights and advocacy services.</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 reported they are supported to be able to remain in contact with the community through outings and walks. Policy includes procedures to be undertaken to assist residents to access community services and a mobility van is available. The activities programme involves linking with other aged care providers and support services for the younger residents.</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>FA</p>	<p>The complaints/compliments policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that five complaints have been received over the last six months and the actions taken, through to an agreed resolution, are clearly documented and completed within the timeframes. Action plans showed any required follow-up and improvements have been made where possible. The facility manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	<p>FA</p>	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Copy of the Code and other information related to rights are in the residents' rooms and displayed throughout the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families, as confirmed by interview</p>

rights.		with the clinical staff. Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Residents and family/whanau report that the residents are addressed in a respectful manner that upholds their rights.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of resident related information. The service has several younger people and their independence and links with age appropriate community resources is encouraged. The residents interviewed and files reviewed evidenced that the individual values and beliefs of the residents are respected. There were no concerns expressed by the residents and family/whānau about abuse or neglect. Staff interviewed reported knowledge of residents' rights and understand dignity, respect and what to do if they suspected the resident was at risk of abuse or neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery and decision making is sought if applicable. The in-service education programme includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whanau. There were no current residents who identified as Maori. The clinical staff reported that there are no known barriers to Maori accessing the services.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The cultural and/or spiritual needs of the residents are provided for in consultation with the resident and family as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The lifestyle plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident. Residents reported that their individual cultural needs, values and beliefs are met. Staff confirmed the need to respect the individual needs of residents.

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family/whanau reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals. The service has access and support from visiting specialist nurses, palliative services and mental health teams. Residents and relatives satisfaction surveys evidenced overall satisfaction with the quality of the care and services provided.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to communicate effectively in English. There are communication strategies in place for residents with cognitive impairment or who have non-verbal means of communication.</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>The strategic and business plans, which are reviewed annually, outline the purpose values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. Waiapu House site specific objectives were also clearly documented in the business plan sighted. A sample of monthly reports to the senior manager showed adequate information to monitor performance is reported including occupancy, financial performance, emerging risks and issues, quality (clinical) indicators (see standard 1.2.3 Quality and Risk Management), results of internal audits and variations to expected service delivery.</p> <p>The service is managed by a facility manager who has been in this role for one year. The facility manager is supported by a clinical services manager, an experienced registered nurse, who was</p>

		<p>appointed to the role in July 2017. Both have completed the organisation's management training. Both are supported by the regional operations manager.</p> <p>Responsibilities and accountabilities are defined in the job descriptions and individual employment agreements reviewed. The facility manager interviewed confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending aged care related seminars and conferences and other relevant training suitable for the position.</p> <p>The service holds contracts with the Hawke's Bay District Health Board for age related residential care, respite and day care services, palliative care, LTC support-Chronic Health Conditions, 'engAGE' GP residential care services and under 65 (YPD). On the day of the audit 66 residents were receiving services; 41 rest home care; 25 hospital level care inclusive of one resident on the 'engAGE' GP programme; under 65 (YPD) nil residents and one resident receiving mental health input.</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>When the facility manager is absent, the clinical services manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a recently employed registered nurse who is experienced in the sector and with interRAI assessments, with support from the regional operations manager. Also, additional support is available from the national quality manager, and the quality manager who currently oversees two facilities. Staff reported the current arrangements work well.</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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, regular resident meetings, monitoring of clinical indicators, incidents including accidents, infections, pressure injuries, falls (with and without injury) staff incidents and health and safety issues.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators. There is monthly reporting to Heritage Lifecare Limited (HLL) support office. From the monthly reports, graphs and summaries of the facility's data are developed against each of the individual clinical indicators and returned to the facility manager. These reports are discussed at the monthly quality and risk/infection prevention and control/health and safety meetings (Q&R/IPC/H&S), at the registered nurse (RN) meetings, and at the staff meetings. The results and graphs (a quality improvement suggested at the previous audit), are now displayed on the family/resident noticeboard and in the staff room. Staff interviewed reported their involvement in these different meetings. Regular internal audit activities occur each month against a calendar of audits. The results are discussed at the Q&R/IPC/H&S meetings.</p>

		<p>Relevant corrective actions are also discussed and were noted in meeting minutes. Meetings with residents are held regularly and they are able to raise and discuss any concerns or issues they have during these meetings.</p> <p>The organisation`s system of monitoring corrective actions which result from internal audits required formal reporting through the facility`s regional operations manager and involvement of the national quality manager if needed. The clinical service manager was aware of any areas identified and described the actions taken to address them. The most recent Q&R/IPC/H&S meeting minutes were sighted and recorded discussion of the last internal audit and the actions to be taken.</p> <p>Policies reviewed cover all necessary aspects of the service delivery and contractual requirements, including reference to the interRAI assessments and other contracts held by this facility. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of any obsolete documents. This is undertaken by designated staff at the organisation`s support office.</p> <p>The national quality manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The organisation has policies and procedures which provide guidance on the Health and Safety at Work Act (2015) and has implemented requirements.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the support office monthly. An electronic system has been developed and implemented for any incidents/accidents reported. The information is entered into the electronic system (GOSH) from the hardcopy incident record, then the form is stamped and filed in the individual resident`s record by the clinical services manager. A selection of these reports was sighted for 2017. Staff understood their responsibilities for reporting and recording adverse events.</p> <p>The national quality manager described essential notification reporting requirements, including for pressure injuries and infection outbreaks. Examples of notifications of significant events made to the Ministry of Health, since the previous audit were reviewed. The facility manager was well informed of statutory and/or regulatory obligations to report. The service`s open disclosure policy was sighted.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of staff records</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>reviewed confirmed the organisation`s policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. New staff members reported, and files reviewed confirmed, that orientation has been completed as required. Staff reported that their orientation prepared them for their role. Staff records reviewed showed documentation of completed orientation and a performance review after three months and then annually thereafter.</p> <p>Continuing education is planned at the facility annually with mandatory training requirements being covered in addition to any site-specific needs. The facility`s quality coordinator interviewed works between two facilities, assists with the development of the annual education plan for staff and is available for advice on any quality management issues. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider`s agreement with the Hawke`s Bay District Health Board (HBDHB). There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments (that is, six staff, with one awaiting the completed competency review).</p> <p>Documentation and records reviewed showed that key competencies (medication, restraint, first aid and hand hygiene) have been addressed for the majority of staff. All staff education records are accessible on the spread sheet maintained electronically. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. No bureau staff are contracted at this facility. InterRAI data is used to guide staffing decisions. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage for the hospital level residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is</p>	<p>PA Low</p>	<p>All necessary demographic, personal, clinical and health information was completed in the residents` files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information entered into the Momentum electronic database. An improvement is required in recording the staff members` names in the progress notes sampled.</p>

<p>uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The admission policy includes the procedure to be followed when a resident is admitted to the home. The admission agreement contains all required information and is based on an aged care association agreement. Entry screening processes are documented and communicated to the resident and their family/whānau to ensure the service can meet the needs of the resident. The residents and family/whānau reported the admission agreement was discussed with them prior to admission and all aspects were understood. Needs assessments from various funders (eg, DHB, ACC) for either rest home, hospital level of care or specialist rehabilitation services were sighted in the resident's files sampled as appropriate.</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>	<p>FA</p>	<p>All residents exit, discharge or transfer is documented using specific forms. The service utilises the transfer forms approved by the DHB and this was confirmed in files reviewed. Known risks are identified to the place of transfer to manage the residents safely. Expressed concerns of the resident and family/whānau are clearly documented including advance directives and enduring power of attorney (EPOA) documentation. This was confirmed in residents' files reviewed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management, using an electronic system, was observed on the days of audit. The staff observed 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 are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Two RNs check medications against the prescription when they are delivered. 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 weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridges and the medication room reviewed were within the</p>

		<p>recommended range.</p> <p>The medications are prescribed through the web based system for good electronic prescribing practices, which includes the live update of any changed medications, the date is recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines are met. The required three-monthly GP review is consistently recorded on the medicine record. There are no standing orders.</p> <p>There were residents in the rest home who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for analysis of any medication errors, with quality projects and internal audits evidencing the reduction in medication errors since the introduction of the web based medication management system.</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>	FA	<p>Policies and procedures implemented cover all aspects of food preparation. Documentation identifies that safe food hygiene management practices are followed.</p> <p>The menu has been reviewed by a registered dietitian as being suitable for the residents living in a long-term care facility. The kitchen has dietary information for all residents and their likes and dislikes are catered for. Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. The residents and family/whānau reported being overall satisfied with the meals (although did provide some suggestions for improvement), and fluids provided, including catering for their individual preferences.</p> <p>Food, fridge and freezer recordings are undertaken daily and meet requirements. The service has submitted a food safety plan with the council, though no external audits have occurred to date. Any non-conformance from the internal reviews or residents' suggestions/feedback from satisfaction surveys have been actioned.</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,</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 Needs Assessment and Service Coordination (NASC) is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>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. The clinical manager reported that they refer residents to different levels/types of care if they are unable to support the resident (such as</p>

where appropriate.		<p>psychogeriatric or secure dementia care).</p> <p>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>The initial assessment, which includes assessment of the residents' health and personal care needs, is completed on the day of admission. Registered nurses utilise standardised risk assessment tools for the initial and ongoing assessments. The interRAI, along with other paper based assessments, information gained from the resident and their family/whanau, referral information, observations and examinations carried out are used as a basis for developing the long-term lifestyle plan. The residents and family/whanau expressed satisfaction with the support provided and 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>In all files sampled, evidence was sighted of interventions related to the desired outcomes. Risks identified on admission are included in the lifestyle plan and these included falls risk, pressure area risk and pain management. The assessment outcomes from the interRAI assessment process were included to update the lifestyle plan. The lifestyle plans are discussed with the clinical team at handover. There are specific treatment plans developed by the multidisciplinary team and DHB staff for the residents admitted under the rehabilitation programme.</p> <p>All health professionals document in the resident's individual clinical file and have access to lifestyle plans and progress notes as part of the integrated file system. Documentation in files reviewed included nursing notes, medical reviews and hospital correspondence. The residents reported that they are included in the lifestyle planning and are aware of any changes and these are discussed with them. Care staff reported they are informed of any changes to lifestyle plans at shift changeover. The residents reported satisfaction with the care provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents 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.</p> <p>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 diversional therapist and activities coordinator plan activities to meet the resident's abilities. Information gained by an activities assessment and resident's history assessment is used when developing the activity plan. There are planned activities that cover physical, social, recreational and emotional needs of the residents. The activities programme is an evolving plan to match weather conditions and resident's abilities. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All the files sampled had lifestyle plans that have been developed within the last six months on the Heritage Lifestyle Plan format. None of these files sampled are due for the six-monthly evaluations. The interRAI assessment tool outcome scores were on the files sampled. The service has processes in place to use the built-in evaluation scores when the service reassesses the resident using the interRAI assessment, and records this on their own paper based evaluation record.</p> <p>When there are changes in the resident's needs, the service changes the long-term lifestyle plan to capture these changes. The long-term lifestyle plans identify the need, interventions and evaluation of the interventions. There are also additional short term plans, such as wound treatment, falls and falls minimisation plans, which capture any short-term changes. Wounds are evaluated at each dressing change and at least weekly by the clinical team. If the issue then becomes a long-term need, these are then recorded and updated on the long-term lifestyle plan. Any changes to lifestyle plans are reviewed by the clinical team (nurses, caregivers, physio-therapist) at handover.</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 choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to radiology, health screening, and medical/surgical specialists. There are several specialists/health providers that also conduct visits to Waiapu House Lifecare such as audiologists, podiatrists and dietitians. 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> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed as necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant education and training for staff. Material data sheets were readily available where chemicals are used and stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building warrant of fitness was displayed at reception and the expiry date was 01 March 2018.</p> <p>Appropriate systems are in place to ensure the residents` physical environment and facilities are fit for their purpose and are maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current and confirmed in documentation reviewed, interviews with maintenance personal and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Residents confirmed they know the processes they should follow if any repairs or maintenance is required, and any requests are appropriately actioned and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. This includes a shower, toilet and basin in all ensuites provided. Privacy is maintained. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Visitor toilets are available throughout the facility in each service area.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provided single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility</p>

adequate personal space/bed areas appropriate to the consumer group and setting.		scooters. Staff and residents reported the adequacy of bedrooms.
<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	Communal areas are available for residents to engage in activities. There are six other lounges available throughout the facility. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents` needs.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry. Laundry staff cover seven days a week and staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. All equipment and resources were available, and a monitoring programme was evident and explained by the staff and maintenance personal. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a designated cleaning team who have received appropriate training. Product data sheets are provided and material data sheets are accessible. Training is provided by a contracted service provider. Chemicals were stored in a lockable cupboard and were in labelled containers. The cleaning trollies when not in use are stored in a locked room with key pad access. Cleaning and laundry processes are monitored through the internal audit programme and by the product service provider.</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>	FA	<p>Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and Civil Defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved 30 July 2008 by the New Zealand Fire Safety Eastern Fire Region. A trial fire evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent being the 26 July 2017. The staff receive training as part of the orientation process. Staff interviewed confirmed their awareness of the emergency procedures and education is provided by the health and safety representative and management.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas barbeques were sighted and meet the requirements for the number of residents at this facility. Water storage tanks are located in the complex, and a generator for power supply can be</p>

		<p>accessed as needed. Emergency lighting is available and is regularly tested. Regular checks of all resources occur. Checklists are developed and implemented. First aid supplies are accessible in all service areas.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a pre-determined time and staff recheck on the night shift at the commencement of their shift. Education is provided to staff on the security reporting system in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by ceiling and wall heaters and residents have a temperature thermostat in each individual room and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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>	FA	<p>There are designated infection control coordinators for both buildings. They have a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meetings and the combined infection control/quality/safety committee meetings. The quality/health and safety committee reviews the monthly quality, risk and infection control issues. The review of the infection control programme was conducted in April 2017. The programme reviews the effectiveness of the infection control programme, education, surveillance and equipment.</p> <p>There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise relatives not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. Staff demonstrated good knowledge and application of infection prevention and control principles.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	FA	<p>The infection control coordinator implements the infection control programme, with support from all staff. Infection control matters are discussed at the monthly meeting. If the infection control coordinator requires additional advice or support regarding infection prevention and control they can access this through the DHB and GP.</p>

infection control programme and meet the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control policies and procedures have been developed by an external infection prevention and control advisory service and reflect current accepted good practice. The service has access to good practice resources from this specialist infection prevention specialist, as well as DHB infection control specialists. The policies are appropriate to the services offered by the facility and reviewed by the national support office.</p> <p>Staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions per the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.</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>There is a designated infection control coordinator. There are online learning modules that are part of the mandatory education programme on infection prevention and control. The infection control coordinator has attended ongoing education related to infection prevention and control to maintain knowledge of good practice.</p> <p>As required, infection control education can be conducted informally with residents, such as reinforcement of infection control practices during a recent outbreak.</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 service uses standardised definitions applicable to aged care that are provided by the external benchmarking service to identify infections. The type of surveillance undertaken is appropriate to the aged care service with data collected on urinary tract infections, influenza, skin infections and respiratory tract infections. There is monthly collection and collation of the types and numbers of infections in both the rest home and hospital services.</p> <p>The data and reporting of the statistics and analysis is provided to the organisational wide governance/quality team. The outcomes are fed back to the staff at the next staff meeting. The infection surveillance records included the review and analysis of the data. With an increase in the number of urinary tract infections, the service implemented actions to reduce the recurrence of spread of the</p>

		<p>infections.</p> <p>The service had an outbreak of norovirus in October 2017. Learning and actions that were implemented from this demonstrated a continuous improvement rating.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provides guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities involved. On the day of the audit, one resident was using an enabler and six restraints were in use. Two residents were each using two forms of restraint. The resident using the enabler, which was the least restrictive, was used voluntarily at their request.</p> <p>Restraint is used as a last resort when alternatives have been explored. This was evident on review of the restraint approval minutes, records reviewed, and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval group, made up of the facility manager, clinical services manager, one registered nurse and the health and safety officer, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' records and interviews with the coordinator that there are clear lines of accountability and that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/whanau/EPOA involvement in the decision making was on record in each case reviewed. Use of restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The registered nurse undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whanau/EPOA. The registered nurse restraint coordinator described the documented process. Families confirmed their involvement. The individual resident's general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed</p>

		assessments were sighted in the records of residents who were using a restraint.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example, the use of sensor mats and/or low beds. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting six monthly. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation`s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff interviewed understood that the use of restraint was to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents` records showed that the individual use of restraints is reviewed and evaluated during the care plan and interRAI reviews, six month restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint committee undertakes a six monthly review of all restraint use which includes all the requirements of the Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the doctor, staff and families. A six monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interview with the restraint coordinator confirmed that the use of restraint has been reduced by three residents over the past six months.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	PA Low	Records were legible with the signature and designation of the person making the entry identifiable. The staff member's name was not recorded in most of the progress notes sampled in the nine of nine residents' files reviewed.	Nine of nine residents' files sampled did not consistently record the staff member's name in the progress notes.	<p>Provide evidence that all records record the name of the staff member making any entry.</p> <p>180 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and	CI	A quality initiative project was conducted on outbreak management from October 2017 to January 2018. After debriefing, an analysis of a previous outbreak of norovirus the service implemented infection prevention and control processes and procedures. This included the analysis of suspected infections against those that were confirmed as infections using standardised definitions. The outcomes of the quality initiative have been reported through the quality system and back to the national clinical governance team. From the analysis of the data and learning from a previous outbreak, changes were implemented. Training and consultation with the DHB and other specialists, critical thinking and clinical reflection resulted in early interventions for suspected infectious diseases. The data analysis highlighted a decrease in the spread of infections when a subsequent resident was suspected to have an infectious disease. The quality initiative records that the goals of the project have been met, evaluation has been completed and reported to the clinical governance team and staff.	The achievement of the infection prevention and control project related to management of outbreaks is rated beyond the expected full attainment. The infection prevention and control team have conducted a project and data analysis on actions to implement when an outbreak is suspected. The quality improvement projects sighted have a documented review process which includes analysis and reporting of findings to management and staff. The project's documentation evidences action taken based on findings and improvement to service provision, with the reduction of the spread of infections during an outbreak. Resident safety has been measured because of the review process, which evidences positive outcomes in reducing the spread of infections and increasing resident's

management in a timely manner.			wellbeing.
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End of the report.