

# Wilding International Limited - Armourdene Rest Home

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

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

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

The specifics of this audit included:

**Legal entity:** Wilding International Limited

**Premises audited:** Armourdene Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 1 March 2018 End date: 2 March 2018

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit: 27**

# Executive summary of the audit

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## 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

Armourdene rest home provides rest home level care for up to 28 residents. On the day of the audit there were 27 residents. The rest home is privately owned and operated by a managing director for 14 years.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management and staff.

The owner/managing director is supported by a full-time administration manager, a full-time and part-time registered nurse. They are supported by caring and long-serving staff. Residents and family interviewed were complimentary of the care and services they receive.

This certification audit identified areas for improvement around internal audits, adverse events, timeframes, interventions, implementation of care, medication documentation, medication competency, self-medicating, food service and maintenance in the kitchen.

## 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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Armourdene staff provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The quality and risk management plan and quality and risk policies describe quality improvement processes. Policies and procedures have been reviewed to reflect best practice. Quality data is collated for infections, accident/incidents, concerns and complaints. Quality data is discussed at meetings and is documented in minutes. Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements. There are human resources

policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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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Residents/relatives confirmed the admission process and the admission agreement was discussed with them. The registered nurse is responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident and their whānau/support person. The GP reviews the resident at least three monthly.

An activity coordinator is employed five days a week. The activities offered are a reflection of the residents group and individual recreational preferences. Community links are maintained.

Medication policies reflect legislative requirements and guidelines.

All meals are prepared on-site. Residents' individual food preferences, dislikes and dietary requirements are met. There is dietitian review of the four-weekly menu. The cooks are trained in food safety and hygiene.

## 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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Armourdene rest home has a current building warrant of fitness. There is adequate room for residents to move freely about the home using mobility aids if required. Communal areas are spacious and well utilised for group and individual activity. All bedrooms have hand basins. There are adequate numbers of communal toilets and showers. Outdoor areas are readily accessible and safe. There is outdoor seating and shade. There is adequate equipment for the safe delivery of care. Emergency systems and supplies are in place in the event of a fire or external disaster. There is a staff member trained in first aid on duty 24 hours. Chemicals are stored safely. The service maintains a tidy, clean environment.

## 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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint should this be required. Staff receive regular education and training on restraint minimisation. No restraint or enabler was in use 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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse has responsibility for infection control across the service. The infection control coordinator has completed infection control education and coordinates education and training for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

## 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)
<b>Standards</b>	0	37	0	5	3	0	0
<b>Criteria</b>	0	83	0	6	4	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. A policy relating to the Code is implemented and care staff interviewed (four caregivers, one registered nurse and one activities coordinator) could describe how the Code is incorporated into their everyday delivery of care.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Residents and their families are provided with all relevant information on admission. Discussions are held with the resident and their whānau or representative regarding informed consent, choice and options regarding clinical and non-clinical services. Written informed general consents were sighted in the six resident files sampled. Resuscitation forms were appropriately signed by the resident and general practitioner (GP). Signed admission agreements were sighted. Discussion with residents and relatives identified that the service actively involves them in decisions that affect the lives of the resident.</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>Health and Disability advocacy brochures are displayed at the main entrance. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. An age concern advocate supports residents without family available to act as advocates. Staff receive education and training on the role of advocacy services, which begins during their induction to the service.</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>The home encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance and transport is provided by the service to ensure that the residents participate safely as desired in community groups such as the library, inter-home competitions, Cossie club, RSA, age concern. Visitors to the home include (but not limited to); age concern, hospice, church groups, entertainers and the RSA coordinator visits servicemen or women at the home.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The complaints officer (administration officer) leads the investigation of any concerns/complaints in consultation with the RN for clinical concerns/complaints. Concerns/complaints are discussed at the monthly staff meetings as sighted in the meeting minutes. Complaints forms are visible. There have been six verbal concerns (five from resident meetings and one relative concern). These have been managed appropriately and outcomes communicated to the residents/relative. There have been no written complaints. Residents and families interviewed are aware of the complaints process. The complaints policy is attached to the admission agreement. A complaints register is maintained.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the Health and Disability Advocacy Service are readily available to new residents and their families. The administration manager or registered nurse discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident meetings. Six residents and two family members interviewed, reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	<p>FA</p>	<p>Caregivers interviewed reported that they knock on bedroom doors prior to entering rooms as observed on the days of audit. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed, and observations during the audit confirmed that</p>

<p>Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>the residents' privacy is respected. Double rooms have privacy curtains in place. Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect and cultural awareness, which begins during their induction to the service. The service received an endorsement from Age Concern for Dignity Champion, as the service provides emergency support for vulnerable persons. The residents' personal belongings are not used communally.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The home is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the home. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of Māori residents. The care plans of two residents who identified as Māori have documented their cultural values and beliefs. The home has access to local Kaumātua and Kuia (one of whom is a Māori resident). Māori residents are supported to attend weekly sessions at Ruaawaawa Kaumātua Charitable Trust. The rest home managing director/owner is of Māori descent and actively supports Māori residents and their families. Some staff are able to communicate in Te Reo with Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The home identifies the residents' personal needs, culture, values and beliefs at the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. Beliefs and values are incorporated into the residents' care plans in the six resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Staff sign a code of conduct and confidentiality clause on employment. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good</p>	FA	<p>Good practice was evident. A registered nurse is available Monday to Friday, one weekend day per week</p>

<p>Practice</p> <p>Consumers receive services of an appropriate standard.</p>		<p>and on-call after hours. Staff attend training relevant to their roles. Policies and procedures reflect best practice. Resident meetings are held monthly, providing residents an opportunity to feedback on all areas of service. Residents and family/whānau interviewed reported that they are very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed satisfaction with the services received. The service was awarded an Age Concern Dignity award based upon their personality, business model and culture of caring for the less fortunate in the aged care sector.</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>There is a policy to guide staff on the process around open disclosure. Residents interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Incident forms reviewed identified family were notified following a resident incident. The RN confirmed family are kept informed. Family members interviewed confirm they are notified promptly of any incidents/accidents and are informed of any GP visits and outcomes. The managing director/owner is on-site daily and operates an open-door policy to meet with residents/family at any time on non-clinical matters. A RN is available to families for discussion regarding clinical matters. Interpreters can be accessed as required. The code of rights is translated into Māori and Chinese.</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>Armourdene rest home provides care for up to 28 rest home level residents. There were 27 residents on the day of audit including one short-stay resident under a Compulsory Treatment order and a private payer (non-assessed) under 65 years. The rest home has been privately owned since 2004. The owner/managing director also has a supported living facility nearby. The service has a small “tight” team of long serving staff that provide a restorative approach to care and a personalised service in a small and homely environment.</p> <p>The 2017 strategic business includes the mission statement and philosophy of care focused around a restorative approach to care, encouraging independence and maintaining links with the community. The business plan has been reviewed with 2018 quality goals in place including maintaining good occupancy and aiming for 100% resident/relative satisfaction results. The service goals include (i) providing and maintain a high-quality service that is reflective in resident’s physical, emotional, spiritual and mental wellbeing and (ii) To continue a Restorative approach to care to promote the resident’s ability to adapt and adjust to living as independently and safely as is possible</p> <p>The owner/managing director is supported by a non-clinical administration manager and a full-time registered nurse (RN) Monday to Friday and part-time RN two days per week and one weekend day (Saturday or Sunday). The full-time RN has resigned and is currently orientating another RN to the full-time role. The owner/managing director and administration manager attend the quarterly ARCC forums as able. The administration manager attends on-site education and has attended a programme Agewise 2017 study day and manages interRAI training. She is registered to attend a leadership study day at the DHB in March</p>

		2018. The owner/managing director has an extensive background in business and human resource management and provides mentorship for the administration manager.
<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	The owner/managing director is available 24 hours. A relieving accounts/wages person provides cover for any planned periods of leave for the owner. The owner covers the administration managers leave. The RNs share the on-call requirement and cover for each other's study days and annual leave.
<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>	PA Low	<p>The quality and risk management plan and quality and risk policies describe Armourdene quality improvement processes. Policies and procedures are reviewed by the relevant person with external advice to ensure policy meets best practice, for example, clinical policies are reviewed by the RNs in consultation with DHB practice nurses as required. Staff are introduced to new/reviewed policies at the monthly staff meetings and sign to declare they have read them.</p> <p>Quality management systems are linked to incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management, however the internal audit schedule has not been completed as scheduled. Data that is collected is analysed and compared monthly for a range of adverse event data (e.g., skin tears, bruising, falls, challenging behaviours and medication errors). Corrective actions are documented and implemented where improvements are identified (link 1.2.4.3). Information is shared with all staff as confirmed in the monthly staff meeting minutes and during interviews. The owner/managing director and administration manager attend the staff meetings. Where required the owner/managing director will provide a written report on operational matters to the staff meeting (as sighted). The owner/managing director is on-site daily and communicates regularly with all staff. There are monthly cooks' meetings. Monthly resident meetings give the residents opportunity to discuss all areas of the services provided and there is documented evidence of any areas of concern being addressed and fed back at the meetings, including outcomes of surveys last completed February 2018. All residents and families were very satisfied with the care provided.</p> <p>A 2018 risk management plan is in place. Staff receive health and safety training and watch a video as part of their induction. All staff are involved in health and safety, which is a topic in the monthly staff meetings. Actual and potential risks are documented on the hazard register, which identifies and documents actions to</p>

		eliminate or minimise the risk. Falls management strategies are developed and documented in the resident care plan for each resident who is at risk of falling.
<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>	PA Moderate	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident, however, three of six incidents reports reviewed did not evidence any RN follow-up. Incident/accident data is linked to the organisation's quality and risk management programme and discussed at monthly staff meetings. Neurologic observations had been commenced for three residents with suspected head injuries, but these had not been completed as per policy timeframes. The owner/managing director reported he is aware of the responsibility to notify relevant authorities in relation to essential notifications. There had been reportable events and there have not been any outbreaks to report.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Six staff files sampled (two registered nurses including the orientating RN, two caregivers, one activity coordinator and one cook) contained all relevant employment documentation. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. Current practising certificates were sighted for the RNs, pharmacy, physiotherapist and general practitioner.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. A senior caregiver is designated for the orientation of staff providing consistency of orientation information and procedures. Staff interviewed believed new staff were adequately orientated to the service on employment. An annual training programme is implemented monthly in conjunction with staff meetings and attendance records are maintained. Training evaluations are completed to identify further learning opportunities. The administration manager is in the process of implementing the on-line learning modules for staff. Clinical staff complete competencies relevant to their role including medication competencies and manual handling. The RN has attended DHB skills workshops as offered. The orientating RN is registered to attend a DHB workshop on advance care planning and interRAI training. The orientating RN is registered to attend interRAI training. The part-time RN is interRAI trained. Some staff are in the process of completing the University of Tasmania dementia care course.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>and support. There is a RN Monday to Friday and some part-time RNs three days a week including either a Saturday or Sunday.</p> <p>On morning shift (7.30 am to 4.00 pm) there are two caregivers on the full shift and one from 7.00 am to 10.30 am to assist with showers. There are two caregivers on the full afternoon shift (4.00 pm to midnight) and one from 4.00 pm to 6.30 pm to assist with the preparation and serving of the evening meal. On night shift there are two caregivers on duty. The RN on call is written in the communication diary.</p> <p>Caregivers complete laundry duties over the three shifts.</p> <p>The residents and relatives interviewed inform there are sufficient staff on duty at all times.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are kept secure in a separate locked area. Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant caregiver or RN, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>A needs assessment is required prior to entry for rest home level of care. The registered nurse (RN) is responsible for the screening of residents to ensure entry is appropriate. Six residents and two relatives interviewed state they received all relevant information prior or on admission. The admission agreement reviewed aligns with the ARC contract. Exclusions from the service are included in the admission agreement.</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>The senior RN (interviewed) described the transfer documentation that is sent with the resident for discharge and transfers. The yellow envelope system is used for transfers to the local DHB. Families were informed of transfers and encouraged to accompany the resident to hospital. A staff member escorts residents to hospital as required. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made and documented.</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>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The supplying pharmacy delivers the medication robotic packs fortnightly or earlier if required. Advised that all medications are checked on delivery by the RN against the medication chart, however, there is no documented evidence of this being maintained at the site. Pharmacy errors are fed back to the supplying pharmacy. Care staff who administer medications have been assessed for competency on an annual basis, however, the RNs did not have medication competencies. Education around safe medication administration has been provided annually. Medications were stored safely. The medication fridge has temperature checks weekly and corrective actions are taken when temperatures are outside of the acceptable range. All medications were within the expiry date. The medication competent caregiver was observed during the lunchtime medicines round and correct procedures were followed.</p> <p>Standing orders are not used by the service. Controlled medications are stored securely, however, there had not been consistent weekly checks.</p> <p>A procedure is in place for the self-administration of medicines. On the day of audit there was one resident self-medicating. The GP has not signed the competency and there is no evidence of monitoring medications for the self-medicating resident.</p> <p>Twelve medications charts (paper-based) were reviewed. Allergies or sensitivities are clearly noted on the medication administration chart. Prescribing of medications met legislative requirements. 'As required' medications had indications for use with the date and time of administration on the signing sheet. Not all administration signing sheets corresponded with the medication chart. The GP had not reviewed four of the twelve medication charts reviewed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>Food service policies and procedures are appropriate to the service setting with a seasonal four-weekly menu. The menu was last reviewed by a dietitian in February 2018. The food control plan has been submitted for verification and are awaiting a site audit before approval. All baking and meals are cooked on-site at Armourdene rest home by cooks who have completed food safety training. Dietary requirements are identified, documented and reviewed on a regular basis as part of the care plan review. Special diets such as diabetic desserts, and alternative choices for dislikes are accommodated. Interview with the cook confirmed that special diets and residents likes, and dislikes were accommodated. The cook is notified of any residents with weight loss or dietary changes. The service also provides "boil ups" on a regular basis as recommended by their Maori residents. Cooked/served food temperatures are recorded prior to serving as part of the internal audit programme (records sighted). Food is transported in hot serving dishes from the kitchen into the dining area (next to the kitchen) and plated by the cook for serving.</p> <p>Kitchen fridge and freezer temperatures are monitored at least daily (sighted). Corrective actions for temperatures outside of range are documented and re-tested. Food stored in the fridge and chillers is</p>

		<p>covered and dated. All foods were labelled, and the cook described rotation of the dry goods. Dry goods are stored in sealed containers in the pantry and kept off the ground. Expiry dates were not evident on the decanted food items.</p> <p>The kitchen is suitable for the size of the service and includes areas for food preparation, baking and cooking. Several areas of the kitchen were noted to be in need of repair (link 1.4.2.1). Chemicals are stored safely. Cleaning schedules were sighted, however, there was no documented evidence of these having been completed.</p> <p>Residents can feedback on the food services at the residents meeting. Residents/relatives interviewed generally spoke positively about the food provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The services 'Planning' policy covers both accepting and declining entry to service. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. The policy outlines potential reasons for declining entry such as there are no beds available or where the acceptance of the admission could potentially affect other residents, or the home cannot provide the level of care required.</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 RN is responsible for completing the first interRAI assessments and six monthly as part of the long-term care plan evaluation (link 1.3.3.3). Initial assessments had been completed within 24 hours of admission including the short-term resident. A range of risk assessment tools are available for use on admission and had been reviewed six monthly as applicable, including (but not limited to); a) falls risk (Coombes), b) pressure injury risk assessment, c) pain assessment, d) dietary profile, e) cognitive assessment and depression scale, f) wound assessment and g) behaviour assessment. The outcomes and supports identified in assessments were reflected in the long-term care plans of three of five long-term resident files reviewed (link 1.3.5.2).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote</p>	PA Low	<p>An initial support plan is completed within 24 hours in consultation with the resident/relative or support person. In addition, care staff record support required and provided to the resident on their shift. This information helps to inform the long-term care plans. Two of five long-term resident care plans reviewed included nursing diagnosis and the required support and interventions to meet the resident goals. Short-term</p>

continuity of service delivery.		<p>care plans were used to document short-term changes in health needs.</p> <p>Resident/family/whānau involvement in the care planning process was evidenced by signatures on the care plan. Record of family notification of care plan reviews was documented on the family notification form in the resident files. Caregivers interviewed were knowledgeable regarding resident cares, care plans and communication systems.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Residents and relatives interviewed reported that residents' individual needs were appropriately met, and they were kept informed of any changes to resident's health status and GP visits. Family communication sheets were sighted in resident files and are maintained by nursing and care staff. There is evidence that family members were notified of any changes to their relative's health including (but not limited to), accident/incidents, infections, health professional visits and changes in medications. When a resident's condition alters, the RN initiates a review by the GP. Caregivers reported that they are informed of any changes in health status at handover. Short-term care plans are used to document short-term needs.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. There is access to the wound nurse specialist (WNSp) from the DHB for advice on wound management if required. Referrals to the WNSp are initiated in discussion with the resident's GP. Wound documentation for two residents with skin tears was reviewed. Both wounds had an initial wound assessment and management plan, however, not all wound documentation had been completed.</p> <p>Continence products are available and resident files included a continence assessment where appropriate.</p> <p>Documentation evidenced RN oversight of resident care, additional assessments and/or monitoring records were sighted. However, not all monitoring charts had been completed as instructed by the care plans.</p> <p>Observation charts and monitoring records were in place for pain, seizures, fluid monitoring and falls (link 1.2.4.3). A shortfall was identified around the monitoring of weight, monthly observations and behaviour monitoring.</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,</p>	<p>FA</p>	<p>The activities coordinator has been in the role at Armourdene for 16 months. She has two years' experience in aged care sector in a similar role. The activities coordinator works 30 hours per week Monday to Friday, however, when there is a community event (festival or tournament) on during a weekend day that the residents are interested in, she is able to be flexible with her work days/time in order to take residents to these events.</p> <p>The activities programme provides a sufficient range of planned activities to maintain resident's strengths and interests, which include the involvement of the residents with the community for example Probus club,</p>

<p>age, culture, and the setting of the service.</p>		<p>Cossie club, museums and community festivals. Resident's social history and their preferred activities were identified on admission and these were documented in the resident's file. Van outings occur at least weekly. Residents and family interviews confirm that the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and birthday celebrations.</p> <p>Individual activity plans have been reviewed at least six monthly. Activities progress notes and attendance records are maintained. The monthly and weekly programme is regularly reviewed by the activities coordinator in conjunction with the residents. Feedback on the programme is sought during the monthly resident meetings and resident surveys.</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 against resident goals is conducted by the RNs with input from the resident, family, caregivers, activities coordinator and the GP. Families are notified of any changes in the resident's ability to meet their desired goals. Residents/relatives interviewed confirmed their participation in care plan evaluations. There is recorded evidence of additional input from specialist or multidisciplinary sources if this is required. There is at least a three-monthly review by the GP for medically stable residents.</p> <p>Short-term care plans are used for short-term changes in health status and had been reviewed, resolved or if an ongoing problem, transferred to the long-term care plan. Not all long-term care plans had been evaluated six monthly (link 1.3.3.3).</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted are; diabetes clinic, ophthalmologist, mental health services and age concern. Residents' files evidence referral letters to specialists and other health professionals. There were no residents at the time of audit requiring re-assessment for higher level of care. Discussions with the RN identified that the service has access to nursing specialists such as wound and continence, gerontology nurse, mental health nurse, a dietitian, physiotherapist and social worker should they be required.</p>
<p>Standard 1.4.1: Management Of Waste And</p>	<p>FA</p>	<p>The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. All chemicals were stored safely throughout the facility. There is an incident reporting system that includes investigation of incidents. Safety datasheets were readily accessible. There was appropriate</p>

<p>Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>protective equipment and clothing for staff. Staff attend chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness that expires 4 August 2018. The owner/managing director oversees the repairs and maintenance for the building. Staff record requests for repairs in a maintenance request book that is checked daily and actioned. There is a planned maintenance schedule in place. Bedrooms have been refurbished as they become vacant. Environmental improvements include the replacement of carpet in the lounge, entrance way and some bedrooms and an upgrade of shower and toilet facilities. The kitchen surfaces and flooring require attention.</p> <p>Essential contractors are available 24 hours. Annual calibration of chair scales, clinical equipment and electrical testing and tagging of equipment is completed by external contractors (last December 2017). Hot water temperatures are checked six weekly and maintained below 45 degrees Celsius. Corrective actions and adjustments have been made where required.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the outdoor areas. Seating and shade is provided.</p> <p>The caregivers interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.</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</p>	<p>FA</p>	<p>All bedrooms have basins. There are adequate numbers of communal toilets and showers. There is safe flooring, seating and hand rails appropriately placed in the shower rooms. There are signs to indicate if the toilets/showers are in use. Residents interviewed confirmed staff provide the resident with privacy when attending to personal hygiene cares. The flooring in each of the communal showers had recently undergone an upgrade.</p>

receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	There are 22 single rooms and three double rooms. The double rooms have privacy curtains. The bedrooms are personalised (as viewed) and spacious enough for residents to move safely around the room with the use of mobility aids. The staff report there is adequate space to carry out the resident cares.
<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	There is easy access to the communal areas. There are two lounges and a separate dining area. Activities occur in communal areas. Residents were observed moving safely between their bedrooms and communal areas.
<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	There is a dedicated cleaner employed for four hours, Monday to Friday, to complete cleaning duties. The cleaner's trolley is stored in a locked area when not in use. The laundry has a defined area for clean and dirty laundry duties. The caregivers also undertake laundry duties. The chemical provider completes monthly quality control checks on the effectiveness of chemical use. Residents interviewed expressed satisfaction overall with the cleaning and laundry service. Personal protective equipment is available for cleaning and laundry duties.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely</p>	FA	Emergency, disaster policies and procedures are documented for the service. Fire drills occur every six months (last fire drill occurred on 9 January 2018). The orientation programme and annual education/training programme include fire and security training. Staff also review a fire safety video as part of their induction to the facility. There is a fire evacuation scheme approved by the fire service 5 August 2014.

<p>response during emergency and security situations.</p>		<p>There are adequate supplies available in the event of a civil defence emergency including emergency power back-up, food, barbeque for alternative cooking, 25,000 litre water tank and civil defence supplies. A call bell system is in place, including all resident rooms and communal areas. All staff have a current first aid certificate. The building is secure after hours with sensor lighting at the main entrance.</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>	<p>FA</p>	<p>There is adequate natural light in all communal rooms. Bedrooms have at least one window and some bedrooms open out onto the deck. There is gas heating in communal areas and electric panel heaters in bedrooms that can be individually controlled.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The RN has responsibility for infection control which is described in the job description. The infection control coordinator oversees infection control for the service and is responsible for the collation of infection events. The infection control programme is reviewed annually.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the influenza vaccine. There have been no outbreaks.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator has completed infection control and prevention education through the professional recognition programme with the DHB. There is access to infection control expertise within the DHB, the wound nurse specialist, and an external infection control consultant. The GP monitors the use of antibiotics.</p>

<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>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Staff complete hand hygiene competencies.</p> <p>Resident education is expected to occur as part of providing daily cares.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at the monthly staff meeting. Trends are identified and analysed, and preventative measures put in place.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is</p>	<p>FA</p>	<p>There are policies and procedures around restraints and enablers. A registered nurse is the restraint coordinator. There were no residents using restraints or enablers on the day of audit. Staff receive training around restraint minimisation and complete a questionnaire. Care staff interviewed were able to describe the difference between an enabler and a restraint.</p>

actively minimised.		
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	There is an annual internal audit schedule that includes environmental and building, clinical, food services, laundry, infection control and restraint audits. Not all clinical audits have been completed as scheduled.	The administration manager completes the non-clinical audits as scheduled, completes a summary of audits, addresses any corrective actions and reports outcomes at the monthly staff meeting. Clinical audits have not been completed for 2017 as per the schedule including admissions, care plans, continence, medication infection control and safe manual handling.	<p>Ensure all clinical audits are completed by the RN as scheduled in the internal audit calendar.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events</p>	PA Moderate	Six incidents for the month of February were reviewed, which included four unwitnessed falls and two medication errors. Not all incidents had been followed up by the RN and signed off. Head injury observations had been commenced by care staff for	<p>1) There was no documented evidence of RN follow-up for three of six incidents (two unwitnessed falls and one medication error).</p> <p>2) Head injury observations for three</p>	<p>1) Ensure there is a clinical assessment and follow-up completed for all</p>

including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.		three suspected head injuries but not completed as per protocol.	unwitnessed falls with suspected head injury had not been completed as per protocol.	incidents. 2) Ensure head injury observations are completed.  30 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements. The RN advised that they check medications on delivery against the medication chart, however, there is no documented evidence to support this. Not all administration signing sheets reviewed corresponded with the medication charts. The restricted medication register evidenced two medication competent staff had checked and signed for the administration of restricted medications. The GP had not reviewed all the medication charts three monthly.	(i) There was no documented evidence on delivery of medications reconciled against the medication chart. (ii) Four of twelve medication charts had signing gaps around administration of inhalers and medications when on leave and signing sheets did not correspond with the medication charts. (iii) Restricted medication weekly checks had not been completed for the month of January 2018 and part of December 2017. (iv) The GP had not reviewed four of twelve medication charts at least three monthly.	(i) Ensure evidence of medicine reconciliation is documented. (ii) Ensure medications are signed when administered or 'the reason not given' is recorded. (iii) Ensure weekly checks of restricted medications are completed weekly. (iv) Ensure GPs review the medication charts at least three monthly.  30 days
Criterion 1.3.12.3 Service providers responsible for	PA Moderate	Administration of medication during the lunchtime round was observed and administration procedures were compliant with policy. All caregivers had	One long-serving RN did not have an annual medication competency completed. Two newly appointed RNs	Ensure RNs complete annual medication

medicine management are competent to perform the function for each stage they manage.		completed medication competencies and annual medication education. Three RNs had not completed a medication competency.	did not have medication competency completed. One RN who was orientating on the day of audit was administering medications.	competencies.  30 days
Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	Armourdene rest home facilitates self-medication and one resident was currently responsible for administration of inhalers and body creams. These were kept safely within the resident's room, however, the monitoring of self-administration medicines on a regular basis, was not recorded. The resident confirmed that staff did check that he was taking the medications. The policy states the GP will sign to declare the resident is competent to self-administer.	On the day of audit, there was one resident who was self-administering. The assessment completed by the RN did not evidence GP input as per policy. The monitoring of self-administration of the residents' inhalers and creams was not recorded.	Ensure there is documented evidence of GP input into the assessment of self-medicating residents and there is documented evidence of monitoring as per policy.  60 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 Low	The kitchen is appropriate to the size of the facility. Dry goods were stored in the facility off the ground and the cook explained rotation of all dry goods. Decanted dry goods did not have expiry dates. There are two fridges and a standing freezer. There are designated shelves within the fridges for dairy, meat and vegetable/grocery items. Kitchen fridge/freezer temperatures and food temperatures are monitored at least daily (sighted). There is a cleaning schedule for the kitchen, however, there is no records to demonstrate this has been completed.	(i) Not all of the dry goods that had been decanted into sealed containers had an expiry date recorded on the container. (ii) Cleaning schedules for the kitchen are not documented as being maintained.	(i) Ensure that all dry goods decanted from manufacturers packing have an expiry date recorded on them. (ii) Ensure the kitchen cleaning schedule is documented as completed.  90 days

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>Initial assessments were completed within 24 hours of admission in the six resident files reviewed including the short-term care resident. First interRAI assessments and long-term care plans had not been developed within the required timeframes. The interRAI assessment had been utilised six monthly for three long-term residents. Long-term care plans had been evaluated for two long-term care residents. The short-term care resident was not required to have an interRAI assessment. The risk was considered to be low, as all interRAI assessments and care plans were current on the day of audit.</p>	<p>1) The interRAI assessments had not been completed within 21 days for two long-term residents. InterRAI assessments had not been utilised six monthly for two long-term residents.</p> <p>2) Four of five long-term resident care plans had not been completed within 21 days and not evaluated six monthly.</p>	<p>Ensure that interRAI assessments and care plans are completed within contracted timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Low</p>	<p>Care plans are developed using assessment tools including interRAI (link 1.3.3.3.), the seven-day initial support assessment, discharge summaries, GP consultation, consultation with family, resident, staff and support persons as applicable. Care plans completed by an RN are goal orientated and reviewed at six monthly intervals (link 1.3.3.3). Not all the care plans including the short-stay resident plan, fully described the interventions required to support the residents identified needs.</p>	<p>Two of five long-term care plans and one short-stay care plan did not include the required support and interventions to meet the resident goals for: (i) Management of anxiety/restlessness and shortness of breath. (ii) There was no challenging behaviour management plan in place including triggers and interventions. (iii) There were no documented early warnings signs/symptoms of declining mental health for one short-term care resident under CTO.</p>	<p>Ensure that care plans document required supports and interventions to reflect the residents' current needs.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers'</p>	<p>PA Moderate</p>	<p>Wound assessments and management plans were in place for two residents with skin tears, however not all documentation was complete. The residents weight and observations are required to be completed monthly, however, there was no evidence of monthly recordings being completed. One resident with known behaviours as documented in</p>	<p>The following shortfalls were identified in the files reviewed:</p> <p>(i) There were no monthly weight and observation records in four files reviewed.</p> <p>(ii) There was no behaviour monitoring chart in place for one</p>	<p>(i) Ensure weight and observations are taken and recorded monthly.</p> <p>(ii) Ensure behaviour monitoring is implemented for</p>

assessed needs, and desired outcomes.		the progress notes, had no monitoring chart in place.	resident with challenging behaviours as reported in progress notes.  (iii) The frequency of dressing changes and evaluations for two of two wounds had not been consistently documented.	residents with behaviours. (iii) Ensure wound documentation evidences evaluation and frequency of reviews.  90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	There has been an upgrade to shower/toilet facilities to meet infection control standards. The planned maintenance plan includes refurbishment of bedrooms as they become vacant. The owner employs a part-time painter as required. The kitchen cupboard surfaces and flooring require attention.	The paint is worn on kitchen cupboard surfaces leaving them porous. The flooring surfaces are worn and cracked in areas. The kitchen requires repairs to ensure infection control standards are being met.	Ensure all kitchen surfaces are sealed to meet infection control standards.  180 days

## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.