

# Maungaturoto Residential Care Limited - Maungaturoto 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 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:** Maungaturoto Residential Care Limited

**Premises audited:** Maungaturoto Rest Home

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

**Dates of audit:** Start date: 23 April 2018 End date: 24 April 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:** 13

# 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
	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

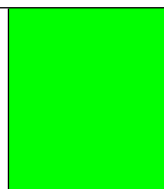
Maungaturoto Rest Home provides rest home care for up to 16 residents. The service is operated by Maungaturoto Residential Care Limited and managed by a nurse manager. Residents and families spoke positively about the care provided.

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` records and staff records, observations and interviews with residents, family members, managers and staff and a general practitioner.

The audit has resulted in five areas requiring improvement for organisational management inclusive of the review process for policies and procedures and how to measure achievement against the quality and risk plan and staffing with staffing considerations based on acuity and management of resident information. There are four areas requiring improvement for service delivery in relation to interRAI information, the assessment process, medication management and food service. There is an area of improvement required for restraint minimisation and safe practice in relation to reviewing and updating of the restraint register, interRAI, nursing assessment, and the restraint minimisation and safe practice policy.

## Consumer rights

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



Standards applicable to this service fully attained.

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

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

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

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

The nurse manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been 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 medium or high risk and/or unattained and of low risk.
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Maungaturoto Residential Care Limited is the governing body and is responsible for the service provided at Maungaturoto Rest Home. A business and quality and risk management plan sighted includes the scope, direction, goals, values and a mission statement. Regular reporting by the nurse manager occurs monthly to the governing body.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection prevention and control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality data is occurring and is reported to the staff/quality meetings, with discussions of trends and follow up where necessary. Meeting minutes and graphs of clinical indicators are documented. Adverse events are documented on appropriate forms and seen as an opportunity for improvement. Corrective action plans are developed, implemented, monitored and signed off when completed. Formal and informal feedback from residents and families is used to improve services. Actual and potential risk are identified, and the hazard register was up to date.

A suite of policies and procedures were available. A contracted quality coordinator is responsible for the policies and procedure and the review process

The human resources management policy is based on current good practice and guides the system for recruitment and appointment of staff. Orientation and the staff training programme ensures staff are competent to undertake their role. An ongoing training plan was available, and all education is recorded. Regular individual staff performance is reviewed annually.

Staffing levels and skill mix are managed by the nurse manager with a roster and on-call system for after-hours being available.

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

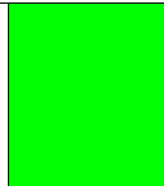
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

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

## 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.

The facility has single rooms including two with ensuite bathrooms. All are of an adequate size to provide personal care.

All building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are adequately sized and maintained at a comfortable temperature. Seating is available in a small courtyard and a shade umbrella can be used when needed.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite, with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed six monthly and there is a sprinkler system and call points installed in case of fire. Residents report a timely staff response to call bells. Staff ensure the facility is secure each night.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler and one restraint were in use at the time of the audit. Restraint is only used as a last resort when all other options have been explored. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and thereafter every two years including all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff understood the restraint and enabler process.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.



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

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	5	2	0	0
Criteria	0	92	0	6	3	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form; however, the required consent to support the use of a restraint is not always obtained (see criterion 2.1.1.4). Advance care planning was sighted in five of six residents' files reviewed. The establishing and documenting of enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints/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/compliments register showed that three complaints had been received since the previous audit and that action was taken through to an agreed solution and are documented and completed within the required timeframes. Any improvements had been made where possible. Each complaint was signed off by the nurse manager and dated. The nurse 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 rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with staff and information provided at reception. The Code is displayed in the main foyer areas together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity,</p>

<p><b>Respect</b></p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating and attending local community activities. Care plans included documentation related to the resident's abilities, and strategies to maximise independence; however not all current interRAI assessments sighted documented up to date and relevant information (see criterion 1.3.4.2 and 2.1.1.4).</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Family are supported and encouraged to take their relatives out on the weekend (eg, to attend church services located next door to the facility).</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p><b>Standard 1.1.4: Recognition Of Māori Values And Beliefs</b></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 nurse manager interviewed reported that there are currently no residents who affiliate with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori, with staff able to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. There is no specific current Māori health plan however the nurse manager reported that all values and beliefs of the resident would be acknowledged with the support of the Te Whare Tapa Wha model and evidenced and integrated into long-term care plans with input from cultural advisers within the local community as appropriate.</p>
<p><b>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</b></p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p><b>Standard 1.1.7: Discrimination</b></p> <p>Consumers are free from any</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. The nurse</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		manager/registered nurse has 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice, however does not always utilise their evidence-based policies (see criterion 1.2.3.4). The facility promotes education of staff and seeks support from the general practitioner (GP) who confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Other services accessed for support included the Needs Assessment and Support Coordination (NASC) service and nurse practitioner.</p> <p>Staff reported they receive management support for external education and access their own professional networks to maintain contemporary good practice.</p> <p>Other examples of good practice observed during the audit included day to day discussions between staff, residents and family members and the observation of staff deescalating potential challenging behaviours and reducing and minimising the risk falls for residents by intervening early.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>The nurse manager interviewed reported that they know how to access interpreter services, although reported this was rarely required due to all residents being able to speak English. One resident who is profoundly deaf is supported by a book that staff write in when wanting to communicate with the resident. The resident is also supported by a volunteer/friend who visits weekly and supports with activities of interest.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	The business, quality and risk management plan was reviewed and outlines the purpose, values, scope and direction of the organisation. The objectives remain the same from the previous year. The documents reviewed described longer term objectives and proposed changes to service delivery. A sample of monthly reports presented at the staff/quality meeting showed the information required was reported as requested and the nurse manager reported to the Board of Trustees monthly.

<p>consumers.</p>		<p>The service is managed by a nurse manager who holds relevant qualifications and has been in the role for nine years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through attending aged care meetings in the community and education provided by the Northland District Health Board (NDHB).</p> <p>The service holds contracts with Northland District Health Board (NDHB) for up to 16 rest home level residents. On the day of the audit there were 11 rest home residents and one hospital resident (dispensation approval sighted and confirmed by HealthCERT). There were no respite care residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the nurse manager is absent, a senior caregiver carries out the required duties with the support of the general practitioner and there is a practice registered nurse on-call twenty four hours for any advice required. A locum registered nurse is available if the leave was for more than two weeks. The senior care giver has worked at this facility for 10 years and is the health and safety coordinator. 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>	<p>PA Low</p>	<p>The organisation has a business, quality and risk plan that reflects the principles of quality improvement for 2016 - 2017. There was no plan sighted developed for 2018. The plan reviewed for the previous two years includes management of incidents and complaints, audit activities, monitoring outcomes, satisfaction surveys and clinical incidents including any infections. Meeting minutes reflected review and analysis of quality indicators and that related information is reported and discussed at the monthly staff/quality meetings. Staff reported their involvement with internal audits. Corrective action plans (CAPs) are developed if there are any deficits from the audits completed. Relevant corrective actions are developed to address any shortfalls. The resident/family survey is completed annually. Very few responses were recorded in the last survey.</p> <p>Policies and procedures reviewed cover all necessary contractual requirements including reference to the interRAI Long Term Care Facility (LTCF) assessment and tool process. Policies and procedures are provided by a quality consultant and are updated as required. New policies are sent to the facility manager who is responsible for replacing documents to ensure they are current and up-to-date to guide staff. There are policies and procedures in the manuals reviewed that are not relevant for this aged care service.</p> <p>The nurse manager is familiar with the Health and Safety at Work Act (2015) and with support of the</p>

		health and safety coordinator both have implemented all requirements. Developed templates/forms are not being implemented by staff as per the policies reviewed (refer to criterion 1.3.4.2) when required.
<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 were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the staff/quality meeting and to the Board if applicable.</p> <p>The nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no infection outbreaks since the previous audit.</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>Human resources management policies and procedures are based on employment practice and relevant legislation. The recruitment process includes reference checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's human resources policies are consistently implemented and records are maintained by the nurse manager.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have completed the required education programme to meet the requirements of the provider's agreement with NDHB. The nurse manager is responsible for all education provided. Staff are enrolled to complete the dementia series training this year. The nurse manager is the only registered nurse. The nurse manager is interRAI trained and has completed the annual competency required to undertake interRAI assessments. Records reviewed demonstrated training completed and annual performance reviews are undertaken for all staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service</p>	PA Moderate	<p>The rosters were reviewed for this small rest home service. The rosters cover the facility 24 hours a day, seven days a week and confirmed adequate staff cover has been provided in the day and afternoon shifts. Staff are replaced in any unplanned absence. At least one staff member is on duty who has a current first aid certificate. The nurse manager is responsible for the staff cover and adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place with staff reporting</p>

<p>from suitably qualified/skilled and/or experienced service providers.</p>		<p>good access to advice is available when needed. The nurse manager and the senior caregiver share this role in the weekends. The senior care giver can still ring the nurse manager any time if required. Care staff interviewed reported there were adequate staff available to complete the work allocated to them despite having two residents who required higher levels of care (refer to 1.3.4.2). There is currently only one care giver on night duty. Two high level needs residents require the use of a hoist for toileting day and night. Family members commented that their relatives received good care.</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>PA Low</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable, however not all files reviewed had identifying resident unique information and not all templates identified within the facilities policies were utilised (see criterion 1.2.3.4).</p> <p>Currently due to the facility renovating the archived records that are retrievable using a catalogue system are off site. The nurse manager interviewed reported that these documents are being stored securely at a board member's home and were unable to be viewed at the time of audit. 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>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. There have been no recent admissions to an acute service. The nurse manager interviewed reported</p>



<p>planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>that in the event of this situation occurring, at the time of transition between services, appropriate information would be provided for the ongoing management of the resident. She stated that referrals would be documented in the progress notes and family of the resident would be kept well informed during the transfer of their relative.</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 Low</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; however, not all medication (inhalers) and supporting consumables (spacers) meet this guideline.</p> <p>A safe system for medicine management (using a paper-based system) was observed on the day 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. The nurse manager/RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on a one to two-week system.</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 stock checks and accurate entries with support of the pharmacist.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines.</p> <p>There were no residents self-administering medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a</p>	<p>PA Low</p>	<p>The food service is provided on site by one of three cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>The service operates with an approved food safety plan and initial registration issued by the district</p>

<p>component of service delivery.</p>		<p>council that expired on the 14 March 2018. There was no evidence of a certificate showing an updated expiry date; however, an audit that took place on the 22 January 2018 by the local council stated that there were no corrective actions and the next audit is due in January 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification, with care staff completing relevant food handling training. All food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines, with the exception of food and beverages not stored appropriately.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family; however, for one resident residing at the facility this was not the case (see criterion 1.3.4.2). 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>	<p>PA Moderate</p>	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, balance and mobility, challenging behaviours, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information; however, not all residents with wounds and/or weight loss and enablers had complete assessments (refer to 2.1.1.4), interventions, evaluations and the support of allied health professionals as required and documented in the facility's policies. The nurse manager interviewed reported that all residents have current interRAI assessments completed by the one trained interRAI assessor on site (nurse manager/registered nurse); however, at the time of audit, the interRAI database reports could not be assessed. Residents and families confirmed their involvement in the assessment process.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information; however, the needs identified by the interRAI assessments were not reflected in the written care plans reviewed (see criterion 1.3.4.2) and/or the relevant templates used as per policy (see criterion 1.2.3.4).</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>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. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care provided and communication between all parties is exceptional. 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>	<p>FA</p>	<p>The activities programme is provided by an activities co-ordinator who supports the residents three hours a week. The residents are also supported at all other times by the care staff, volunteers and families who are encouraged and supported to take their relatives out as appropriate.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions and satisfaction surveys. Residents interviewed confirmed they find the programme fun with emphasis on the white board games. Activities are offered at times when residents are most physically active and/or restless.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change however the interRAI evaluations did not reflect the current needs of the resident (see criterion 1.3.4.2). Where progress is different from expected, the service responds by initiating changes to the written plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds; however, the templates found in the facility's policy are not used (please see criterion 1.2.3.4). When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to a physiotherapist and mental health services for older people. The resident and the family 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>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provided relevant education and training for staff. Material data sheets and product information is available where chemicals were stored and utilised. Staff interviewed knew what to do should any chemical/spill occur. A spill kit was available and accessible if needed.</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>FA</p>	<p>A current building warrant of fitness dated expiry 01 July 2018 was sighted and is displayed at reception to the facility.</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>Appropriate systems are in place to ensure the residents` physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the nurse manager and observation of the environment. The maintenance person was not available for interview. The environment was hazard free, residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Staff and residents confirmed they know the processes they should follow if any repairs or maintenance is required. They also stated that 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>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Only two residents` rooms have ensuite facilities. There are five separate showers and seven toilets available in close proximity to the resident`s individual rooms. Appropriately secured and approved handrails are provided in the toilet and shower areas and other equipment/accessories are available to promote residents` independence. There are separate toilets allocated for staff and visitor use.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photographs, paintings and other personal effects displayed to promote a homely atmosphere. There is adequate room to store mobility aides, wheelchairs, hoists and other equipment. Staff and residents reported the adequacy of bedrooms. One smaller room is designated for respite care residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. There is a separate lounge and sunroom available for residents. The dining room is in close proximity to the kitchen and the lounge areas. There is easy access for residents and staff. Furniture sighted was comfortable and appropriate to the setting and meets the residents` needs.</p>

<p>their relaxation, activity, and dining needs.</p>		
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The laundry is undertaken onsite by staff. Staff interviewed demonstrated a sound knowledge of the laundry process, dirty to clean flow and the handling of soiled linen. Personal protective equipment (PPE) was readily available. The sluice room is directly opposite the laundry. The laundry has two washing machines and two clothes dryers. An outside clothes line is available and is preferred by staff in the warmer months. All material data sheets and product information are accessible in the laundry. Residents/families interviewed reported the laundry is managed effectively and personal clothes are returned in a timely manner.</p> <p>The care staff are responsible for the laundry and cleaning and are trained for each role. Chemicals are stored in a lockable cupboard and the trolley is stored in the sluice room when not in use. Monthly orders are placed for any resources or supplies required. Representatives from two companies contracted check all supplies and equipment on a regular basis and provided ongoing education for all staff in respect to the cleaning, kitchen and laundry processes.</p>
<p><b>Standard 1.4.7: Essential, Emergency, And Security Systems</b></p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>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 fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service 27 July 1994. This was verified by talking directly to the Northland Fire Service. The last fire evacuation drill was 09 April 2018 and a record of attendees and a fire evacuation questionnaire was completed by all staff. Drills are provided six monthly as required. The orientation programme for all staff includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency including water, food, blankets, mobile phones and gas for a barbecue were sighted and meet the requirements for the 12 residents currently, or 16 when the service has full occupancy. There is no power generator on site but water storage is available and emergency lighting is tested regularly.</p> <p>Nurse 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>Doors and windows are locked at a predetermined time. The security policy states that all staff and residents will be assured of a safe and secure environment. The staff provide regular checks of the facility on all shifts.</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>All residents' rooms and communal areas have opening external windows. Each room can be ventilated adequately and natural light is provided. One half of the facility has central heating (underfloor heating system) and the other has fixed electric heaters. The temperature of the facility was comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the GP and pharmacist as required. The infection control programme and manual are reviewed annually.</p> <p>The nurse manager/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported to staff at monthly meetings and to the board.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role since her role as nurse manager commenced. She has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2010 (see criterion 1.2.3.3).</p>

<p>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>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the nurse manager/registered nurse and on line educational training. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>Education with residents is generally on a one-to-one basis and includes reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, gastro-intestinal, respiratory tract and scabies. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions however the surveillance data is not captured on the facilities templated policy documents (see criterion 1.2.3.4). Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers.</p> <p>The facility has had a total of five infections since October 2017 with surveillance documentation highlighting that the facility in November 2017, January 2018 and March 2018 did not have any infections, and overall in 2017 a total of nine infections. One resident has been identified with frequent infections due to co-morbidities and another resident is now deceased. The resident's file reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.</p>



<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint minimisation policy sighted is dated 19 January 2010. The restraint coordinator is the nurse manager who oversees the enabler and restraint management in the facility.</p> <p>On the day of the certification audit two residents were documented in the restraint register as using enablers. During the review of the resident's individual records it was identified that both residents made voluntary decisions for safety reasons to initiate the use of an enabler. One resident initiated this in 2015 and continues to use an enabler. The other resident initiated the enabler use in 2011 (when a respite care patient). This resident is now in long term care. The interRAI assessments/ nursing assessments and the long term care plan do not reflect the change from enabler to use of a restraint. This resident is no longer able to make an informed decision voluntarily and is therefore using a bedrail as a restraint. This was verified by the general practitioner interviewed and in the documentation. The consent forms reviewed had been signed by the GP, family representative and the nurse manager for use of an enabler not a restraint.</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>	<p>FA</p>	<p>The restraint approval group is made up of the nurse manager and the GP. The nurse manager is responsible for the approval and use of restraints and the restraint processes. It was evident from review of restraint meeting minutes, resident records and interviews with the nurse manager that there are lines of accountability, that all restraints are to be approved and the overall use of restraints is being monitored and analysed. There is evidence of family involvement. The use of an enabler and/or restraint is part of the interRAI process and the plan of care (refer to 2.1.1.4).</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>	<p>FA</p>	<p>The assessment process for the use of restraint is documented and included all requirements of the standard. The RN undertakes the initial assessment with input of from the resident's family. The nurse manager described the documented process. The GP is involved in the final decision on the safety of the use of a restraint. The assessment process identified the underlying cause, history of restraint use, any previously, any cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraint is minimised and the nurse manager described how alternatives to restraints are discussed with staff and family members. When a restraint is in use frequent monitoring occurs to ensure the resident is safe. Access to advocacy is provided when requested. Dignity and privacy are maintained and respected. The restraint register needs to be reviewed to reflect the resident that was using an enabler which is now a restraint due to a change of health status. (refer to 2.1.1.4). Restraint is used only as a last resort. Care staff interviewed are fully informed of safe restraint use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The use of a restraint is documented, reviewed and evaluated during the interRAI re-assessment process and the care plan reviews six monthly. The family are involved in the assessment and evaluation process. Family were interviewed of the one resident using a restraint and they were satisfied with the restraint process. The evaluation form sighted covers all requirements of the Standard including future options to eliminate the use of the restraint.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The GP and the nurse manager complete six monthly reviews of the standard. Restraint is reported to the staff/quality meetings held monthly. Minutes were sighted of the meetings held. The numbers of restraint/enabler use is reported, the effectiveness of the enabler/restraint, the competency of staff and the restraint/enabler education provided is reviewed. The restraint register is reviewed annually but currently needs to be updated refer to 2.1.1.4).</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 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	PA Low	The business, quality and risk plan was reviewed for 2016 – 2017. There was no plan sighted for 2018 – 2019. The nurse manager interviewed reported that this had not been discussed with the Board. Staff interviewed stated they were involved in the internal audits and understood quality improvement.	The business, quality and risk plan for the previous two years had not been fully evaluated to set the objectives for 2018-2019. Business has rolled over for the current year and staff are continuing to perform their same responsibilities and tasks allocated.	<p>Ensure the business quality and risk plan is reviewed and that a new plan is instigated for the next two years as documented in policy.</p> <p>180 days</p>
Criterion	PA Low	The relevant nursing care manuals were sighted. Policies, processes for all	Three policy and	Ensure the

<p>1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>		<p>nursing care responsibilities are developed but on review procedures are not followed by staff and documented best practice forms are not completed when required. Any obsolete documents are retained in the manuals reviewed.</p>	<p>procedure manuals were sighted. The manuals contained current, newly reviewed and documents that needed to be made obsolete. Procedures documented are not followed and templates provided are not implemented by the service provider (eg, wound care management plans, infection control and short-term care planning forms). Plans are documented on pieces of paper.</p>	<p>required templates are implemented and utilised on the appropriate templates provided by the quality consultant which align with the policies documented. Obsolete documented are removed from the manuals sighted as per policy.</p> <p>180 days</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>PA Low</p>	<p>The business quality and risk plan is implemented. The current plan remains the same from 2017. There is a documented process on how to measure achievement against the plan. Internal audits are completed in a timely manner as per the audit schedule. The planning, delivery and evaluation of services provided is documented but this has not been completed for 2016 – 2017.</p>	<p>There is a documented process in place to measure achievement against the business, quality and risk plan. The achievement against the 2016 -2017 plan was not evident at the time of audit. There is no plan for 2018 that has been developed and implemented.</p>	<p>Ensure the organisation's process is followed to measure achievement against the business, quality and risk plan.</p> <p>180 days</p>

<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>Policies and procedures were not available in relation to service provider availability for this rest home service. A rationale for the resident with hospital level dispensation has not been developed and/or implemented to guide staff. Another resident is needing to be re-assessed currently (refer to 1.3.4.2) for decline in health status. The roster reviewed reflects one caregiver on night duty but due to the current situation arising this will need to be reviewed. Staff interviewed commented that one resident would be left in their hoist should the other high dependency care resident require their hoist at the same time on night duty. The on call senior care giver and the RN are on call if required.</p>	<p>There is no clearly documented and implemented process which determines service provider levels and skill mix to provide safe service delivery. There is one hospital level resident with a dispensation from HealthCERT but consideration is required currently for another resident with declining health status to ensure the shifts are adequately staffed. The night shift does not meet the needs of two residents who require the use of hoists and two carers.</p>	<p>Ensure a documented and implemented process is available for determining service provider coverage of this service. The roster is reviewed to ensure adequate staff are rostered on the night duty to meet the care needs of the current residents.</p> <p>30 days</p>
<p>Criterion 1.2.9.1</p> <p>Information is entered into the consumer information management system in an accurate and timely manner, appropriate to</p>	<p>PA Low</p>	<p>On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's admission record reviewed, however all six files viewed did not have unique identifiers evidenced on residents' progress notes.</p>	<p>The sample of files reviewed did not contain unique identifiers on residents' progress notes.</p>	<p>Ensure that all documents related to residents contain uniquely identifying information (for example, NHI and full name or date of</p>

the service type and setting.				birth).  180 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	In observing the medication trolley that was locked in the locked nurse manager's office, six inhalers that were prescribed and in use were sighted with no residents' name labels (the boxes had been thrown out). There were two spacers, one of which was not named with both spacers requiring cleaning. At the end of day one the nurse manager contacted the pharmacy and the inhalers were renewed with residents' name labels.	Not all inhalers and spacers in use are labelled with the resident's name. Two spacers required cleaning.	<p>Provide evidence that all medication and supporting consumables are dispensed and stored as per best practice medication guidelines and policy.</p> 180 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation,</p>	PA Moderate	Food procurement, production preparation and disposal comply with current legislation and guidelines. The cook interviewed was aware of the guidelines. One package of frozen meat did not have an expiry date or 'best by' date visible. An unopened boxed packet of custard was found in the fridge with an expired date of 21 April 2018. Two residents' beverages in their cups were found in the fridge unlabelled and not dated.	Not all food in the fridge and freezer have expiry dates documented. Expired food was found in the fridge in the kitchen. Not all residents' beverages found in the fridge in the kitchen were labelled with the	Provide evidence that the storage of food complies with current legislation and guidelines.

<p>delivery, and disposal comply with current legislation, and guidelines.</p>			<p>residents' name and date when put in the fridge.</p>	<p>60 days</p>
<p>Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Moderate</p>	<p>At the time of audit, the nurse manager reported that all interRAI assessments are up to date. Five of the six residents' files reviewed had current interRAI assessments. However, these interRAI assessments did not reflect current support and interventions required for the residents (refer to 2.1.1.4). The interRAI assessments had information that was relevant to previous interRAI assessments and the initial admission and had not been correctly updated. All five of the six residents' files reviewed had associated assessments and up to date long term care plans that were current and reflected the support and required interventions. The nurse manager/registered nurse had access to the interRAI database and was able to complete resident interRAI assessments but was unable to access reports to show levels of care and when interRAI assessments are due.</p> <p>One resident, prior to permanent placement, had been admitted to the facility for respite care on a regular basis since 2016. An initial assessment and short-term care plan had been developed and was sighted. The resident was assessed and admitted as a permanent resident on the 16 April 2018 due to a deterioration in health and carer fatigue. At the time of audit an updated admission assessment and short term care plan had not been developed to meet the required timeframes.</p> <p>There are seven current wound management plans relating to five residents (two residents have two wounds) identified in the wound management folder. All wounds were identified in an incident report. Seven of the seven wound care management plans did not show all required evidence of assessment, planning and/or evaluation or have unique identifiers for multiple wounds. The templates available (initial wound assessment, care plan and monitoring forms) were not utilised. All five residents' frequency of dressing required, residents expected timeframe of wound healing was not identified. The wounds were identified with the use of a body map. Three residents were identified as having a pressure injury. A grade was not identified nor have photos being taken to evidence the initial pressure injury and healing. The pressure injuries</p>	<p>At the time of audit, the auditor and/or service provider were unable to access the reports on the interRAI database to show the level of care report and the resident interRAI assessments due.</p> <p>Not all interRAI assessments completed by the nurse manager reflected the current needs and outcomes of the resident.</p> <p>One resident admitted on the 17 April 2018 still requires an admission assessment and short-term care plan.</p> <p>Not all residents with weight loss or residents who had wound care management plans had an assessment</p>	<p>To provide evidence that all interRAI assessments are completed to reflect the current needs and outcomes for the resident.</p> <p>To provide evidence that all assessments are completed to support residents with changes to their health and to meet timeframes and contractual requirements.</p> <p>To provide evidence that all residents who require a higher level of care are reassessed to</p>

		<p>have not been seen by the GP. The wound management policy does not stipulate that the resident is required to see the GP within a required timeframe if a wound or pressure injury occurs, nor does the policy document when a referral should be considered for specialist support. The nurse manager/registered nurse reported that the wounds are being dressed and all wounds are healing, that she aware of the requirements of reporting a grade three or greater pressure injury using a section 31 document. Staff interviewed demonstrated that they were aware of the specific needs of the residents to reduce and minimise risk.</p> <p>Two residents had documented weight loss. One resident had lost a total of 11 kg from December 2017 to April 2018. The nurse manager interviewed reported that this resident had been discussed with the GP; however, there was no evidence available to support this. The facility had not completed a food diary and or increased weighs to weekly however supplemental nutrition had been commenced for both resident's.</p> <p>One resident requires a reassessment for a higher level of care (Refer 1.3.3 - rest home tracer)</p>	<p>completed.</p> <p>One resident reviewed using tracer methodology requires a reassessment for a higher level of care to meet the required needs of the resident.</p>	<p>reflect those needs.</p> <p>90 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Low	<p>The policy reviewed stated that the use of enablers shall be voluntary and the least restrictive. The intention for using an enabler was to promote or maintain resident independence and safety. Two residents were recorded in the restraint register and clinical records as using enablers. One resident is hospital level care and the decision was made by the resident to use a bedside rail for safety reasons. The other resident is currently rest home level care. The residents' clinical records reviewed evidenced that one of the two residents was now unable to make an informed decision and is totally immobile. The individual resident's health status has changed since an initial short term care admission when the enabler was approved.</p>	<p>The current restraint minimisation and safe practice policy has not been reviewed since 2010. One of two residents recorded as using an enabler was found to be using a bedrail as a restraint and not an enabler.</p>	<p>The organisation's restraint minimisation and safe practice policy needs to evidence that this has been appropriately reviewed. The current interRAI documentation, (assessment and care plan) and the restraint</p>



				register require updating to reflect the resident's needs and use of the restraint.  60 days
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## 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.

No data to display
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End of the report.