

Kaylex Care Limited - Eastcare Residential Home

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:	Kaylex Care Limited	
Premises audited:	Eastcare Residential Home	
Services audited:	Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 14 February 2019	End date: 15 February 2019
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:	36	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Eastcare Residential Home provides rest home and dementia level care for up to 47 residents.

This recertification audit was conducted against the New Zealand Health and Disability Services Standards and the provider's contract with the Waikato District Health Board (WDHB).

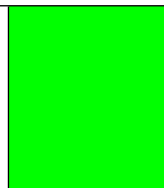
Changes since the previous 2017 audit include appointment of new manager in 2018 and reducing the number of beds available in a dementia wing by one.

The resident's family members and a general practitioner interviewed expressed their satisfaction with the care and quality of services provided. Only a small sample of residents (three) were able to be interviewed.

Seven areas requiring improvement were identified during this audit. These relate to the timeliness and content of care plans, the provision of 24-hour activity plans for residents in the dementia units, evaluation of behaviour monitoring charts, a kitchen surface, safe storage of chemicals and the external area outside one of the dementia wings.

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 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.

A complaints register is maintained. When complaints have been received, these are investigated, and the information related to these is recorded. Residents said they had been informed about the complaint management process and felt supported to raise any concerns.

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.		Standards applicable to this service fully attained.
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The operator and facility manager are maintaining frequent and clear communication with all staff. There is always a qualified and experienced manager available. The quality and risk management systems are well established and service delivery was being regularly monitored. Adverse events were being reliably reported, and investigated to determine cause and prevention. People impacted by an adverse event were notified. The operator understands the obligation to make essential notifications and actions this when required.

Staff were being recruited and managed effectively. Staff training in relevant subject areas has been occurring regularly. There were adequate number of skilled and experienced staff on site to meet the needs of each resident group.

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 developed, 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. Residents are referred or transferred to other health services as required.

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

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

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents 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.		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 facility meets the needs of residents. All internal and external areas were clean and the building and chattels are well maintained. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. Some of the external areas are accessible and safe for residents' use.

Waste and hazardous substances are well-managed. Staff use protective equipment and clothing. Laundry is undertaken onsite and evaluated for effectiveness.

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

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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Eastcare Residential Home has a philosophy and practice of no restraint. There were no restraint or enablers in use on the days of audit.

Policies and procedures meet the requirements if a restraint is required and staff education is ongoing.

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	38	0	3	4	0	0
Criteria	0	86	0	3	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>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.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Residents admitted to the dementia unit have an enacted enduring power of attorney and these documents were sighted in residents' files on the day of audit. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents 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>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family 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>	<p>FA</p>	<p>Records and staff and resident interviews showed that the service is managing all complaints received according to its policy and Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The complaints register showed four complaints received since the previous audit. The documentation attached to these confirmed investigations occurred and that these were resolved to the satisfaction of the people involved. A resident interviewed was fully informed about the complaints process and said they had no hesitation in raising concerns or lodging complaints. They had experience of their complaint being taken seriously and said that action was taken immediately to address the matter. There have been no complaints received by the DHB or the Office of the Health and Disability Commissioner since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>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 pack, resident agreement and discussion with staff. 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 Respect</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p>

<p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</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 attending different activities and participation in clubs of their choosing for example volunteering for hospice, care in craft, attending church and events occurring in the community. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Staff support residents in the service who identify as Māori 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 whānau. The clinical leader interviewed reported that there are three residents who affiliate with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is no specific current Māori health plan, however all values and beliefs that are important to the resident are 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 required. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Whanau were not available for interview, however the Māori resident interviewed reported that staff acknowledge and respect their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>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 including the attending of church and right to privacy. The resident satisfaction survey and minutes of the residents' meeting confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	<p>FA</p>	<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. All</p>

<p>harassment, sexual, financial, or other exploitation.</p>		<p>registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the knocking on residents' doors before entering and day to day conversation between staff, residents and their families.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents being able to speak English, staff able to provide interpretation as and when needed and the support of family.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>On the days of audit there were 36 residents occupying the available maximum of 46 beds. Twelve of these are assessed as requiring rest home level care and 24 people, across two separate dementia wings, requiring secure care. Two of the rest home residents are funded by the Accident Compensation Commission and the records for one of these was reviewed in depth.</p> <p>The facility manager who has been employed since 2018, is a registered nurse with a current practising certificate. The manager is attending ongoing performance development in subject areas related to nursing and management. The manager and owners have regular contact with other age care providers and relevant DHB staff.</p>

		The company (Kaylex Care Ltd) has an overarching strategic/business and risk plan for the three facilities it operates and each facility has a unique annual business plan. Review of the 2018/19 plan for Eastcare Residential Home showed that goals within it are monitored and updated by the company's senior management team. This team comprises the two owners, a general manager and an operations manager. The facility manager reports to all members of the management team.
<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	When the facility manager is absent, their role is substituted by the owner/operator who is an RN and has many years' clinical experience working on site. This person visits the facility at least weekly and is informed about the residents and their care needs. The owner/operator is always on call for advice as is the operations manager who is an RN from another facility in the group. A senior caregiver also steps up to oversee management of the facility from time to time. Staff and the families and residents interviewed said services were managed to their satisfaction.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A pre-audit document review confirmed that the organisation's policies and procedures are controlled, and are updated two yearly or as required to meet known best practice.</p> <p>Residents and their families interviewed confirmed they are consulted about any proposed changes in service and are being kept informed by monthly residents' meetings or notices.</p> <p>Quality data such as incidents/accidents and infections are collated, analysed and shared at the facility managers' monthly 'Skype' meeting. Statistical and narrative data is displayed in the staff room, any events are communicated at shift handover, and unwanted trends are discussed at bi-monthly staff meetings. There is documented evidence of corrective actions on incident/accident reports, on the internal audit tools where a deficit or gap is identified, in the hazards register, and in complaints documentation. The service also completes quality improvement plans when service deficiencies or opportunities to improve are identified. A quality initiative to closely monitor the weight of residents at risk has been recently implemented. The new approach uses an industry standardised assessment tool to monitor how an individual's energy output is replenished.</p> <p>The organisation's annual quality plan, business plan and associated emergency plans, document actual and potential risk to the business, service delivery, staff and/or visitors' health and safety. Health and safety policies are compliant with the current legislation and interviews confirmed that the owners understood their obligations. Environmental risks are communicated to visitors, staff and consumers as required through notices, or verbally, depending on the nature of the risk. Review of staff meeting minutes showed that health and safety including the hazard register and risks related to</p>

		residents are discussed.
<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>There are well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed these are reviewed and discussed at staff meetings. Adverse event data is collated and analysed monthly by the facility nurse manager and then reported to the general manager, the owners and the other facility managers. The collated results and a narrative summary are displayed in the staff room. Staff confirmed that they are kept informed about incident and accident trends.</p> <p>Interviews and review of incident data on the days of audit confirmed that incidents are communicated at shift handover, and trends are discussed at staff meetings. Each resident's care record contained a summary of incidents which facilitates a ready review of risks.</p> <p>The owner is responsible for essential notifications and reporting and understood the statutory and regulatory obligations. There have been no incidents requiring notification to the DHB or Ministry of Health. The appointment of a new manager was notified in 2018.</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>Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. A new caregiver reported that the orientation process prepared them well for their role. Another staff member said they had no orientation to their specific role, but this was disputed with them by the owner/operator at the time. This person's staff record and other personnel records reviewed contained 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 either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff working in the dementia care areas have either completed or are enrolled in the required education. The facility manager is maintaining annual competency requirements to undertake interRAI assessments and an external RN is contracted to complete these assessments on site. The effectiveness of this requires review as a lack of detail in some long-term care plans was identified (refer to criterion 1.3.5.2)</p> <p>The sample of staff records reviewed showed attendance at ongoing training and completion of</p>

		annual performance appraisals.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7) is documented and implemented. The facility adjusts staffing levels to meet the changing needs of residents. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and the family member interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with absent staff replaced by casual or bureau staff. All the care staff on duty have a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>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>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. 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/or 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 on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements. Residents admitted to the dementia unit have been seen by a specialist and admission agreements sighted showed the resident's enduring power of attorney has consented for the resident to be admitted to the service.</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>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' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed documentation of discussions had with the GP, ambulance and family before transfer. Transfer notes showed that all required information was provided with use of the 'yellow envelope'. Progress notes also showed ongoing communication between the facility and local hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic 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 RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and accurate entries.</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 was consistently recorded on the medicine chart. Standing orders are not used. Vaccines are not stored on site.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The food service is provided on site by a qualified chef, one cook and kitchen team, 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.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines, but the wooden servery/cabinet in the main dining room needs repairs. The service operates with an approved food safety plan and registration issued by Ministry of Primary Industries and expires 27 June 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The chef has undertaken a safe food handling qualification. All but one kitchen assistant has completed relevant food handling training. Training in food handling is booked for March 2019 for this person.</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. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident 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 currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. 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>FA</p>	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, 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. All residents have current interRAI assessments completed by the clinical leader who is a trained interRAI assessor. An independent contractor, a trained interRAI assessor/registered nurse, visits the facility once a week to assist with the completing of interRAI assessments as required. 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>PA Moderate</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 in the GP's, progress notes, short term care plans and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>Long term care plans reviewed did not always reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were not always reflected in the long term care plans reviewed. Not all resident's files reviewed had a behaviour management plan that included triggers and interventions for behaviours.</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>Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is good. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels 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>PA Low</p>	<p>The activities programme is currently provided by the activities co-ordinator as the facility's diversional therapist had recently resigned and was no longer at the facility. The facility manager interviewed stated that a new diversional therapist has been appointed and is due to commence work at the facility 4 March 2019. They will be working alongside the activities co-ordinator and both staff will continue to support the residents Monday to Friday 9.00 am to 5.00 pm.</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 monthly and as part of the formal six- monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys and day to day discussions with residents and families. Residents interviewed confirmed they find the</p>

		<p>programme exciting and fun.</p> <p>A separate calendar has been developed for residents in the dementia unit, however a lot of the planned activities see residents from both the rest home and dementia unit participating together. All residents are encouraged to part take in planned activities within the facility and regularly out in the community, for example, attending the movies, shopping trips, daily walks and special events organised. Specific activities/events are also planned for ladies and men to separately attend, such as high tea and visiting the motor car museum.</p> <p>Activities for residents in the secure dementia units are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. These activities included regular walks around and outside the facility, activities known to distract the resident and one to one support, however residents' files reviewed in the dementia unit did not have a 24-hour behaviour activity clock to support the residents who exhibit different behaviours.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</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. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Evaluations of behaviour monitoring forms does not occur. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, weight loss and falls. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<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 mental health services for older people, respiratory and cardiac teams. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>PA Moderate</p>	<p>All staff who handle chemicals have completed safe chemical handling training. An external company is contracted to supply and manage chemicals and cleaning products and provide staff with product information. Material safety data sheets were available where cleaning and laundry chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Appropriate signage is displayed where necessary.</p> <p>Chemical products were accessible to residents in both dementia wings, an improvement is required.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>A current building warrant of fitness (expiry date 01 December 2019) is publicly displayed. There has been a change to the interior of Tui (secure unit) since the previous 2017 audit. One bedroom has been decommissioned to accommodate more space in the dining room. This has not affected the fire evacuation plan. The outside area for residents in Tui wing (dementia) is neglected and the gardens contained noxious weeds, this requires improvement. Otherwise the building layout, design features and furniture in both dementia units is safe and suited for the needs of confused older people. There are pictorial signs on the toilets and bathrooms and each resident's bedroom is identified with name and images that the individual relates to.</p> <p>Electrical equipment was tested and tagged in September 2018. Visual inspection, records reviewed and interviews with maintenance staff and the operators confirmed that planned and reactive repairs and maintenance is ongoing. The building, chattels and equipment is in good repair. Medical equipment (for example, blood pressure monitors, weigh scales, and the standing hoist) are serviced and recalibrated according to the suppliers recommendations.</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 sufficient numbers of accessible bathroom and toilet facilities throughout the facility. All toilet and shower facilities are shared, with a total of seven bathrooms and eleven toilets allocated for residents. All bathrooms and toilets have functional locking systems for privacy. A staff and a visitors' toilet are designated. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. All ablution areas are in good condition. The testing and monitoring of hot water temperatures occurs monthly. Records showed that temperatures are within a safe range.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms have a single occupant. Attention is paid to the layout of furniture in bedrooms to allow residents and staff to move around safely. There was evidence that residents had their own furniture and possessions. Sufficient space is available in corridors and most rooms to store mobility aids and wheel chairs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each of the three wings has its own lounge and dining room and these are located within easy walking distance from the resident's bedrooms. The dining area in one of the dementia wings has been increased in size by removing a bedroom. There is a separate quiet area where families can visit their relatives inside and outside the facility.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Designated cleaning and laundry staff are on site seven days a week. These staff have achieved qualifications in safe handling of chemicals and are provided with ongoing health and safety education as confirmed in interview with staff and review of their personnel records.</p> <p>Staff follow established routines for cleaning and all areas are maintained as hygienic. Site inspection revealed no concerns with daily cleaning. Chemicals are decanted into clearly labelled containers (refer to 1.4.2 for improvement required regards resident access to cleaning chemicals).</p> <p>All the laundry is being managed on site according to known protocols for dirty/clean flow and the handling of soiled linen. There have been no concerns expressed from staff, resident or relatives about cleaning or laundry services since the previous audit. Cleaning and laundry processes are routinely monitored for effectiveness via the internal audit programme, from the external cleaning product supplier and through resident/family surveys and feedback.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines 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 described the procedures to be followed in the event of a fire or other emergency. A fire evacuation plan has been approved by the New Zealand Fire Service. The most recent fire drill occurred in December 2018 and was repeated in January 2019 to ensure all staff had attended. Staff interviews confirmed their understanding of evacuation procedures in the two dementia wings. The</p>

		<p>recent trial evacuations did not identify any issues of concern in moving residents to safety. The orientation programme includes fire and security training.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, communication devices (a walkie talkie) and gas BBQ's were sighted and meet the requirements for the maximum number of residents. Sufficient potable water (400 litres) is stored in the building to meet the needs of 46 residents for three days. Apart from a backup battery for lighting (which is regularly tested) there are no generators on site for power outages. The protocol is to hire one.</p> <p>Call bells alert staff to residents requiring assistance. Staff were observed to respond within reasonable timeframes to these.</p> <p>Appropriate security arrangements are in place. There are security stays on all windows. The only access to the building is via the main entrance, and this door is locked at a 5pm each day.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents' bedrooms and communal areas have sufficiently sized windows and opening doors for ventilation. Each communal area has at least one heat pump which provides warmth or cooling and electric panel heaters are in each bedroom. Family and residents interviewed said the home was kept at a comfortable temperature in all seasons.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>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 an external provider as required. The infection control programme and manual are reviewed annually.</p> <p>The clinical leader/registered nurse is the designated IPC coordinator and supported by a senior caregiver whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager and tabled at the monthly full staff and management meetings.</p> <p>The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell and that signage will be placed at the main entrance in the event of an infectious outbreak. A bi-yearly newsletter is sent out to all families and reminds them that if they have been unwell in the past 48 hours, not to enter the facility. Staff interviewed understood related 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>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role since March 2018. She has undertaken external training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information are 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 procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in January 2019 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing, sanitiser dispensers, gloves and hand washing signs are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<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 suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained</p> <p>Education with residents is generally on a one-to-one basis and has included 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</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Twenty-seven residents and 22 staff consented to the flu vaccine in June 2018.</p> <p>The facility has had a total of 36 infections since June 2018 through to and including January 2019. Residents' files 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. Benchmarking does not occur.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service had no restraint or enablers in use at the time of this audit and it has always taken the approach of using alternatives to restraint. The only restraint interventions have been one off emergency restraint events. The last events recorded were in 2015. This is made clear in the organisation's restraint minimisation and safe practice policies and associated procedures. The reviewed policy meets the required Health and Disability Services Standards and clearly describes emergency restraint authorisations and the requirements to meet this standard if restraint is required. The definition of an enabler is congruent with the definition in NZS 8134.0.</p> <p>Sensor mats are in position to alert staff when residents who pose a falls risk are ambulatory. In-service education focuses on alternatives to restraint and managing challenging behaviour. Interviews with the staff and review of individual training records confirmed that education on maintaining a restraint free environment and safe practice occurs at orientation and at least every year after that.</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 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>Food preparation, storage and delivery complies with current legislation and guidelines. The chef interviewed was aware of the guidelines. There is a cleaning schedule which is signed off as required when completed. The wooden servery/cabinet in the dining room was observed to be clean, however requires some maintenance.</p>	<p>The surface of the food servery cabinet in the rest-home dining room is deteriorated and poses an infection risk.</p>	<p>Ensure that all surfaces in the food services area are intact and able to be cleaned.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of</p>	PA Moderate	<p>It was evident from staff interviewed that they knew the residents well. Family/whanau interviewed stated that they were happy with the care and</p>	<p>Two of six residents' long-term care plans</p>	<p>Provide evidence that</p>

service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		communication provided. An initial assessment and short-term care plan had been created when the residents were admitted. Progress notes sighted showed specific interventions and support that was provided by staff. Two residents admitted to the facility in October 2018 did not have long term care plans developed within 21 working days of admission as required. The same two residents at the time of audit do not have long term plans to support staff in caring for the resident.	are not completed within the required timeframes.	each stage of provision is provided within the required timeframes to safely meet the needs of the resident. 180 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	All residents have individual details and client specific initial care plans developed at the time of admission. All residents have an interRAI assessment completed. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process. Six residents' files were initially reviewed from the rest home and dementia unit and the sample then extended to include a further five residents' files. Five of 11 residents' files did not have interventions in the residents' long-term care plans that reflected the information recorded in the interRAI assessment nor interventions individual and specific to the resident. Five of five residents' files in the dementia unit did not have a behaviour management care plan including triggers and related interventions.	Not all residents' long-term care plans reflected the current and individual needs of the residents. Not all residents in the dementia unit had a behaviour management care plan that identified triggers and related interventions of the resident presenting with a challenging behaviour.	Provide evidence that the residents are receiving care that meets their needs. 180 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources,	PA Low	All residents had an individual challenging behaviour form that identified the behaviour, intervention and outcome. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Observation on the day of audit identified residents in the dementia unit exhibiting different behaviours, and the staff supported the residents well with activities, distractions techniques and one to one support. Families confirmed their involvement in the assessment process and care	Five of eight residents' files reviewed in the dementia unit did not have a 24-hour behaviour clock to support management of the residents'	Ensure that all residents in the dementia unit have a 24-hour challenging

and interests) that are meaningful to the consumer.		provided. Three residents' files were initially reviewed and extended to five files as the 24-hour behaviour activity clock to identify behaviours that are exhibited by the resident and activities had not been completed.	challenging behaviours.	behaviour activity clock to meet contractual requirements. 180 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	The staff knew the residents well and when interviewed could recall the interventions best suited to reduce and minimise the resident's presenting challenging behaviour and meet the needs of the resident. Evaluations of short-term care plans were sighted. Three residents' files in the dementia area were initially reviewed and this sample was extended to five files. These five residents in the dementia unit who presented with challenging behaviours had behaviour monitoring forms that had not been evaluated to support care planning and the development of the 24-hour behaviour activity clock.	Five residents' files reviewed in the dementia unit have behaviour charts to show challenging behaviours, interventions and outcomes but this information has not been evaluated.	Provide evidence that all behaviour monitoring charts are evaluated to identify possible trends and support care planning. 180 days
Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial	PA Moderate	Although there were policies and processes for maintaining a safe environment which includes staff being informed about this during orientation, an incident of harm to a resident who had ingested soap was reported by staff in 2018. Shampoo and bars of soap were found in the communal showers of Korimako (a dementia unit) and cleaning products had been left out by a new cleaner in the other dementia unit on day one of the audit. One of the cleaners advised they always check and remove potentially harmful products when found.	Confused residents have access to potentially toxic substances (cleaning products, soap bars and shampoo). These were removed on the day of the audit.	Ensure that chemical products are always stored safely and not within reach of confused residents. 30 days

authority requirements.				
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>PA</p> <p>Moderate</p>	<p>Inspection of all external areas confirmed that dementia residents in the two wings, have access to the safe and secure outside spaces. Rest home residents have ready access to external areas including the facility main entry and exit. There are shade and safe seating areas from each of the three wings. The gardens outside Tui are neglected and contained noxious plants (Belladonna) which were removed during the audit.</p>	<p>The garden in Tui wing contains plants that are noxious and potentially harmful to humans. These plants were removed on day one of the audit. The area has become neglected and run down and requires renovation to provide residents an interesting and safe place to explore.</p>	<p>Ensure all external areas are safe and suitable for confused residents.</p> <p>30 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.