

# M V and C D Hodson - Westella Homestead

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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 Q-Audit 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:

<b>Legal entity:</b>	M V and C D Hodson
<b>Premises audited:</b>	Westella Homestead
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 6 June 2019    End date: 7 June 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	24

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Westella Homestead provides rest home and dementia level of care for up to 26 residents. The service is operated by CD Hodson and managed by a business support manager (BSM), clinical quality lead (CQL) and clinical team leader (CTL). Occupancy was 24 at the time of audit. There were no significant changes since the last audit. Residents and family/whanau spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Service Standards and service's contracts with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, staff, management and general practitioner.

There were 14 identified areas requiring improvement. The improvements relate to recognition of Maori values and beliefs, consumer information management system, human resources management, service provider availability, service provision requirements, planning, service delivery/interventions, medicine management, laundry services, shower and bathing facilities, facility specifications, restraint minimisation, infection control management and surveillance of infections.

## 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.

Some standards applicable to this service partially attained and of low risk.

Residents and families are provided with information about the Health and Disability Commissioners Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided 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. The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. There is 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 with complaints resolved promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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CD Hodson is the governing body and are responsible for the service provided at Westella Homestead. Dalcam Healthcare Limited is contracted to provide management services at Westella Homestead. Business and quality and risk management plans include the risks (scope, direction, goals, values and mission statement of the organisation). Monitoring of the services by the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meets the changing needs of residents. Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents are assessed by the Needs Assessment Service Co-ordination (NASC) prior to entry to the service to establish a level of care. A registered nurse (RN) is responsible for the provision of care and documentation at every stage of the service delivery. The initial support plans, baseline assessments and care plans guide staff in the safe delivery of care to the residents. The care plans are resident, and goal orientated and reviewed every six months or earlier if required. Input from the resident/family is evident in the service delivery. Integration of allied health and a team approach is evident in the resident files reviewed. The general practitioner (GP) reviews residents three monthly or more often as required. Residents interviewed confirmed that they were happy with the care provided.

Planned activities are appropriate to the residents' assessed needs and abilities and residents advised satisfaction with the activities programme.

There is a secure electronic medication system at the facility. Medication charts are reviewed three monthly by the general practitioner. The registered nurses and senior caregivers that administer medication have annual medication competency assessments and receive annual education.

Residents' food preferences and dietary requirements are identified at admission and accommodated. All meals are cooked on-site. The kitchen is well equipped for the size of the service. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Nutritional snacks are available 24 hours.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The facility meets the needs of the residents and is clean and well maintained. There is a current building warranty of fitness. Electrical equipment is tested as required. Communal areas and individual rooms are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken offsite 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 prompt staff response to call bells and security is maintained.

## Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Westella homestead has processes in place for determining safe and appropriate restraint and enabler use. The facility is a secure unit, and on the day of audit there were no residents requiring the use of restraints or enablers. Staff receive training in restraint minimisation and challenging behaviour. On the day of the audit there were two rest home residents' who have requested to remain in the facility, despite it being a secure facility they are able to independently exit the facility at any time.

## Infection prevention and control

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Infection control management systems are in place to minimise the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control coordinator reporting to the clinical team leader.

There is an infection prevention and control programme for which external advice and support was sought; this is reviewed annually. An infection control nurse is responsible for this programme. The clinical team leader is responsible for staff education and surveillance.

Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is appropriate to the size and complexity of the organisation according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. Surveillance results are benchmarked with an external provider. The results of surveillance are reported to organisation management.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	32	0	7	6	1	0
<b>Criteria</b>	0	80	0	7	6	1	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Westella Homestead has developed policies, procedures and processes to meet its obligation in relation to the Code of Health and Disability Services Consumer 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 ongoing training as verified in the 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 show 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. 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>As part of the admission process at Westella homestead, residents are given a copy of the Code, which includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were displayed and available in the facility. Family members and residents interviewed were aware of the Advocacy Service, how to access this and their right to have support persons. The CTL and staff provided examples of the involvement of Advocacy Services in relation to residents' care.</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. 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 encounters 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>The complaints policy and associated forms meet the requirements of the Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to make a complaint. The service aims to acknowledge the complaint in five working days and outcomes are to be reported in 10 working days. If more time is needed reason for delay is noted.</p> <p>The complaints register reviewed showed that complaints have been received over the previous year and this year and actions were taken through to an agreed resolution, are documented and completed in a prompt manner. Action plans show any required follow up and improvements that have been made where possible. The CTL is responsible for the day to day complaints process with the BSM supporting where complaints are escalated to the DHB, HDC, or Ministry of Health. There have been no complaint investigations by the Ministry of Health (MOH), Health and Disability Commission (HDC) Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. All staff and family/whānau interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and Nationwide Health and Disability Advocacy Services during admission and discussion with staff. The Code is displayed at the reception area and around the facility together with information on advocacy services and how to make a complaint</p>

their rights.		and feedback forms. Westella Homestead's resident information booklet was in place. Signed residents' agreements were sighted in records reviewed. Service agreements meet the requirements of this standard and district health board requirements. Monthly residents' meetings are conducted.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed maintaining privacy throughout the audit days. All residents have a private room. Residents are encouraged to maintain their independence by engaging in regular exercises. Care plans reviewed included documentation related to the residents' abilities and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious, social needs, values and beliefs had been identified, documented and incorporated into their care plan. Residents who identified as Maori had no Maori health care plan in place and advisory groups were not being involved (refer to 1.1.4.3).  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.
Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	PA Low	Staff support residents in the service who identify as Maori 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. Family/whanau interviewed reported that staff acknowledge and respect their individual cultural needs. Recognition of Maori services in the care planning process could be improved.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic,	FA	Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the resident. Values and beliefs are discussed and incorporated into the care plan (refer 1.1.4.3). Residents and family members interviewed confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans reviewed. The resident/family satisfaction survey confirmed that individual needs are being met.

cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	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. 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. Management representatives stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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.  Staff know how to access interpreter services, although reported this was rarely required as all resident were conversant with the English language. Staff can provide interpretation as and when needed; the use of family members and communication cards is encouraged.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	CD Hodson is the governing body and are responsible for the service provided at Westella Homestead. CD Hodson have contracted the management of Westella to Dalcam Healthcare Limited (Dalcam). The BSM for Dalcam was interviewed and advised they report monthly to the board of directors. The BSM oversees two other sites owned by CD Hodson.  The directors meet quarterly and 2014-2019 strategic plan and 2019-2020 business plan were sighted. The BSM reported that the service is on a transition process from hardcopy documents to a new electronic system namely the Stella library.

		<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and long-term objectives and the associated operational plans. Monthly/quarterly reports to the board of directors/owners showed adequate information to monitor performance is reported including potential risks, contracts, human resource and staffing, occupancy, maintenance, quality management and financial performance.</p> <p>The BSM is supported by the senior management team of clinical quality lead, Information Communication and Technology (ICT). Development Manager (DM) and Financial Manager (FM) and senior management team support the (CTL) in managing the facility and provision of services. The management team meets monthly. All members of the management team are suitably qualified and maintain professional qualifications in management, finance and clinical skills. The service is managed by a CTL who holds relevant qualifications and has been employed by Dalcam for six years and has been in the role of CTL for three years. Responsibilities and accountabilities are defined in a job description and individual employment agreement.</p> <p>The service holds contracts with (DHB, MOH) for YPD, respite and day care services and complex medical conditions, respectively. 24 residents were receiving services on the days of the audit. At the time of the audit there were two rest home residents who consented to being in a secure environment and 22 assessed as requiring dementia level care (one of whom was under 65 years).</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 CTL is absent the RN carries out all the required duties under delegated authority supported by the BSM and CQL. The RN is experienced in the sector and able to take responsibility for any clinical issues that may arise. 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</p>	<p>FA</p>	<p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit programme, regular family/resident satisfaction survey, monitoring of outcomes, clinical incidents and accidents including infections and surveillance.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related</p>

<p>management system that reflects continuous quality improvement principles.</p>		<p>information is reported and discussed at the management team meeting/quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent family/whanau 2019 survey showed that respondents were satisfied with the services provided.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI long Term Care Facility (LTCF) assessment tool process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents (refer 1.2.9.5).</p> <p>The business support manager described the process for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The BSM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>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. There were two residents who had falls and required admission to the local district health board. Neurological observations were not consistently completed post falls (refer 1.3.6.1). Adverse events data is collated, analysed and reported to the management and directors, respectively. There is an open disclosure policy in place. Any communication with family and general practitioner (GP) following adverse events and if there is any change in the resident's condition is recorded in residents' records. Family/whanau and the GP interviewed confirmed they are notified in a timely manner.</p> <p>The Clinical Quality Lead described essential notification reporting requirements, including for pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks and missing persons. They advised there have been notifications of significant events made to the MOH since the previous audit such as change in the management structure.</p>
<p>Standard 1.2.7: Human</p>	<p>PA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of</p>

<p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>Moderate</p>	<p>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>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 providers agreement with the DHB. All staff have completed dementia level training, and some are enrolled in the required course. Staff performance is monitored, and annual performance appraisals were sighted in all files reviewed. There are enough trained and competent RNs who maintain their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. Competency assessment questionnaires are completed for medication management and restraint/challenging behaviour.</p> <p>Orientation of the CTL to the managers role could be improved.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Low</p>	<p>Residents and family interviewed supported this. Observations and review of a four -week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is RN cover during the day. CTL reported they come in when called in emergency situations any time after hours. An improvement is required to ensure the diversional therapist has 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>	<p>PA High</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files reviewed. Clinical notes were current and integrated with GP and allied health service provider notes. Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals (refer 1.3.3.3). 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>No personal or private resident information was on public display during the audit. An improvement is required to ensure residents' past records are kept for the required retention period.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services</p>	<p>FA</p>	<p>The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. All resident files reviewed had the appropriate needs assessments prior to admission to the service. The enduring power of attorney (EPOA) of each resident requiring specialised</p>

<p>is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>care, has consented to the resident being admitted. Admission agreements reflect all the contractual requirements. Families and residents reported that the admission agreements were discussed with them in detail by the CTL. Information about the service includes the specific dementia care services provided, including the use of technology to facilitate management of residents with dementia in an environment of minimal restrictions and risk. Full details of the services location and hours, how the service is accessed and the process if a resident requires a change in the care provided, is also included.</p> <p>Four of the five resident files reviewed had admission agreements signed on admission. One admission agreement was signed on the day of the audit.</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. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are recorded in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policy is comprehensive and identifies all aspects of medicine management. An electronic medicine management system (Medimap) is implemented to ensure residents receive medicines in a safe and timely manner. RNs and care staff who administer medications have been assessed for competency on an annual basis and attend annual medication education. The GP prescribes medication electronically. Pre-packaged medications received are checked on delivery from the pharmacy, against the medication chart by the RN and stored safely in a locked cupboard located in the treatment room. The staff administering medications complied with the medication administration policies and procedures as evidenced in the observed medication round on the day of audit. There were no residents who self-administer their own medicines on the day of the audit. There were no controlled drugs in use or on site on the days of audit. The controlled drug register evidences accurate records. The temperature of medication fridge was monitored and recorded as evidenced.</p> <p>Medication errors are reported to the RN and recorded on an online incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>All medication charts sampled had photo identification and allergy status. Not all medication charts reflected documented evidence of the effectiveness of the prn medication administered.</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>FA</p>	<p>The food service policies and procedures included the principles of food safety, ordering, storage, cooking, reheating and food handling. There is a well-equipped kitchen and all meals are prepared and cooked on-site by the kitchen staff. There was a food service manual in place to guide the staff. All staff has had food safety training. The service has a valid food control plan in place.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. The RNs complete a nutritional profile for each resident on admission and provides the kitchen with the dietary requirement form. Additional or modified foods are also provided by the service. There was evidence that there are additional snacks available over 24 hours.</p> <p>Fridge and food temperatures were monitored and recorded daily. Cooked meals are plated from the kitchen directly to the dining room. The meals were well-presented, and residents confirmed that they are provided with alternative meals as per request. Special equipment to meet resident's nutritional needs were sighted. All residents are weighed regularly. Residents with weight loss problems are provided with food supplements. Residents interviewed spoke positively about the food provided.</p> <p>Food procurement, production, transportation, delivery and disposal comply with current legislation and guidelines. The service ensures the effectiveness of chemical use, cleaning, and food safety practices in the kitchen is maintained. A signed cleaning schedule was sighted.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.</p> <p>There was enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed. Residents requiring assistance with feeding were served first. The dining rooms are clean, warm, light and airy to enhance the eating experience.</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>There is a documented policy on decline of entry to the service. When a resident's entry to the service is declined, the resident/whanau are referred to the referrer to ensure that the resident is admitted to the appropriate level of care provider. The reason for declining entry is communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services. The CTL reported that the district health board needs assessors and social workers contact the manager to discuss the suitability of the resident prior to sending the resident and their family to view the facility.</p>
<p>Standard 1.3.4: Assessment</p>	<p>FA</p>	<p>Prior to admission, residents have their level of care identified through a needs assessment by the Needs</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>Assessment and Service Coordination (NASC) agency. The RNs utilises standardised assessment tools to gather information regarding the resident, in consultation with the resident and their relatives where appropriate. Files sampled contained appropriate completed assessment tools and interRAI assessments were reviewed at least six monthly or when there is a change to a resident's health condition. The interRAI assessments have been completed for all resident files sampled within the required timeframes. Cultural, sexuality and intimacy needs have been identified for the residents. On admission an activity profile is developed based on the activity assessment and this is reviewed six monthly with the care plan. Additional assessments were completed according to the need e.g. including nutritional, continence and pressure assessments. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident's bedroom or the whanau room with the resident and/or family/whanau present where possible.</p> <p>A medical assessment is undertaken within five days of admission and reviewed as a resident's condition changes, or three monthly.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support the resident needs to meet their goals and desired outcomes. The care plans reviewed were resident focused and individualised for one of five resident files reviewed. Acute care plans were used for short-term needs (link 1.3.6.1). Relatives and resident interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people.</p> <p>In the five resident files sampled the care plans are evaluated six monthly on the day the new care plan is generated or more frequently as the resident's condition dictates.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the RN initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications were evidenced on resident records and confirmed at resident and staff interviews. Residents and family/whanau members expressed satisfaction with the care provided. Documentation in the care plan did not always include the detailed interventions required to meet some residents assessed needs, desired outcomes or goals as their condition changed.</p> <p>Adequate dressing supplies were sighted in the treatment room. The service had no wounds or pressure sores on the day of audit. Registered nurse and caregivers interviewed state there was adequate access</p>

		<p>to equipment and medical supplies including continence and wound care supplies.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission.</p> <p>Acute care plans document appropriate interventions to manage short-term changes in health, however there was no acute care plan in place for one resident with a chest infection. Neurological observations had not been completed as per policy for unwitnessed falls for three residents.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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 service employs one diversional therapist (DT) and an activity assistant who work 40 hours a week to operate the activities programme. Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities profiles are developed, and a holistic 24/7 activities programme is created that is meaningful to the resident. Activities provided are appropriate to the needs, skill, age and culture of the residents. The one resident under 65 years had a detailed activity plan in place. The activities plans are reviewed six monthly or more often and the reviews documented the resident's progress towards goals. The activities staff interviewed displayed an understanding of resident requirements.</p> <p>The weekly activities plans are posted in the lounge and included exercises, gardening, bingo, church services and quizzes. The activities are physically and mentally stimulating. The activity plans sampled were well-documented and reflected the resident's preferred activities and interests. Residents activity participation logs were sighted, and a positive uptake was noted. The interviewed resident and families indicated that the activities provided by the service are adequate and enjoyable. Van outings to local attractions take place and residents have signed consents for going on outings, on record. Community involvement is maintained through the weekly church services, external entertainers and van outings. Residents were observed playing cards, gardening, playing pool, wandering in the garden and enjoyed a van trip on that day of the audit.</p> <p>A residents' meeting is held monthly by the activity team. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered by residents and family.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	<p>FA</p>	<p>Resident care is documented on each shift by care staff in the progress notes however registered nurse reviews are not documented in progress notes (link 1.3.3.3). If the care staff notes any change, it is reported to the RN.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are</p>

<p>manner.</p>		<p>carried out by the RN in conjunction with family, GP and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan (refer 1.3.6.1).</p> <p>Short-term care plans are initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all 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. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the District Health Board (DHB). Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to public hospital 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. There is a designated chemical handler who has completed the required chemical handling training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using them.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	<p>PA Moderate</p>	<p>A current building warrant of fitness is publicly displayed. 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 maintenance personnel and observation of the environment.</p> <p>The service is secured by electronic gates with security cameras and high fences. Residents can walk</p>

<p>facilities that are fit for their purpose.</p>		<p>around freely throughout the facility and grounds. There is GPS tracking for residents who have been identified with dementia related wandering. External areas are safely maintained and are appropriate to the resident groups and setting. Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. An improvement is required to ensure that all environmental areas are safe for residents.</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>PA Low</p>	<p>Communal toilets and showers have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Maintenance of wall surfaces in most shower/bathing facilities could be improved.</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. Personal privacy is maintained. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids and wheelchairs. Staff and residents confirmed the adequacy of bedrooms.</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>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	<p>PA Low</p>	<p>Laundry such as bedding, and towels is washed off site by a contracted provider and personal laundry is washed on site or by family members if requested. Family/whanau interviewed expressed satisfaction with</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>the laundry management and that clothes are returned in a timely manner. There are designated cleaning personnel who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through internal audit programme and corrective actions are acted upon. Handling of soiled linen including having clear separate areas for clean and dirty laundry need to be improved.</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>	<p>FA</p>	<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 the preparation for disasters. These describe procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 23 May 2019. The orientation programme includes fire and evacuation. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas were sighted and meet the requirements for the 24 residents at the service. Water storage tanks are located around the complex, and a generator is hired when needed. Emergency lighting is regularly tested. 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>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 are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto outside garden or small patio areas. Heating is provided by heaters in residents rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers,</p>	<p>PA Low</p>	<p>Westella Homestead has an established infection control (IC) programme. The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The infection control programme, reviewed annually, establishes, maintains and monitors procedures covering infection control practices. The infection control practices are guided by the infection control manual in</p>

<p>and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>conjunction with the public health advisor at Mid Central Health.</p> <p>The registered nurse is the designated infection control person with support from all staff. It was noted that the infection control nurse did not have a signed appointment letter and job description on file. Infection control monthly reports were not integrated into the staff meetings. The clinical team leader manages infection control training. Education has been provided for staff as evidenced. On the day of audit there was one resident diagnosed with chest infection (link 1.3.6.1).</p> <p>It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted. There are enough hand sanitisers placed throughout the facility. Residents and staff are offered the influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control nurse (ICN) together with the clinical team leader is responsible for implementing the infection control programme and reports to the clinical team leader, who reports to the general manager (link 3.1.1).</p> <p>The ICN and observation verified there are enough human, physical and information resources to implement the infection control programme at Westella Homestead. Training records sighted, and interview verified the ICN attended infection control training. External resources and support are available through the DHB and public health department when required.</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</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. The policies reflect current best practice and meet requirements.</p> <p>Staff interviewed verify knowledge of infection control policies. Staff are observed to be compliant with generalised infection control practices.</p>

type of service provided.		
<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 verify staff have received education in infection control and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectations.</p> <p>Resident education occurs in a manner that recognises and meets the residents' and the families' communication style, as verified by resident and family interviews.</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>	PA Low	<p>In line with Health and Disability Services Standards (HDSS) surveillance of infections is occurring and is the responsibility of the infection control nurse (ICN).</p> <p>Daily incidents of infections and the required management plan are presented daily at handover, and via electronic alerts, to ensure early interventions. Surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions.</p> <p>Incidents of infections are presented at the quality meetings and any ongoing corrective actions discussed. Infection control data is not presented to staff at staff meetings, as showed by meeting records, infection control records and staff interviews. The service participates in internal benchmarking within the organisation's other facilities as well as external benchmarking with similar service. Surveillance data evidences incidents of infections are low.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. The service demonstrated that the use of restraint was actively minimised. The residents are free to wander around the gardens. There were no locked doors and residents can enter or leave the building as they feel like. There was no evidence of any resident using physical restraints or enablers on the day of the audit. Interviews with staff, residents and their family members confirmed physical restraint and enablers were not being used in the facility.</p> <p>The two residents assessed as requiring rest home care have requested to stay at the facility after rest home level of care changed to dementia level of care. These residents have consented to being cared for in a designated secure unit (refer 1.3.3), as they did not want to leave the facility. Review of these residents' files evidenced written consent records, requesting their desire to stay at the facility despite it being secure. At interview it was verified that the residents have the means to independently exit the unit at any time and the provider does not intentionally restrict the residents' normal access to the environment.</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>PA Low</p>	<p>The clinical team leader is the restraint coordinator. The assessment and approval process for restraint use included the restraint coordinator, registered nurse, resident or representative and medical practitioner. On the day of audit there were no residents on restraints. It was noted that there was no signed appointment letter or job description evidenced on restraint coordinators file.</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 1.1.4.3</p> <p>The organisation plans to ensure Māori receive services commensurate with their needs.</p>	PA Low	<p>Guidance on tikanga best practice is available and is supported by staff who identify as Maori in the facility. There was no current Maori health plan developed for residents with input from cultural advisory groups where appropriate.</p>	<p>Residents who identify as Maori did not receive services that commensurate with their needs.</p>	<p>Provide evidence that advisory groups are consulted where appropriate and Maori health care plans are developed where required.</p> <p>180 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an</p>	PA Moderate	<p>Staff orientation is generic for all roles. The CTL has been employed by service for six years and been in the role for three years. Staff reported that the orientation process</p>	<p>There was no evidence that the CTL was given specific orientation</p>	<p>Provide evidence that the CTL has</p>

<p>orientation/induction programme that covers the essential components of the service provided.</p>		<p>prepared them adequately for their role. Staff records reviewed showed documentation of completed orientation and performance reviews after three months of service. Orientation of the CTL to the manager's role could be improved.</p>	<p>relevant to the manager's role.</p>	<p>been orientated to the manager's role.  90 days</p>
<p>Criterion 1.2.8.1  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 Low</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe delivery, 24 hours a day, seven days a week. The service adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when required. Care staff reported there were adequate staff available to complete the work allocated to them. Evidence of Diversional Therapist first aid certificate was not sighted.</p>	<p>There was no evidence provided to show that the Diversional Therapist had a current first aid certificate.</p>	<p>Provide documented evidence that the Diversional Therapist has undergone first aid training.  180 days</p>
<p>Criterion 1.2.9.7  Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.</p>	<p>PA High</p>	<p>Archived records are held securely on site and are readily retrievable. No personal or private resident information was on public display during the audit. Residents' past care plan records and interRAI assessments were being destroyed.</p>	<p>Records of past care plans and interRAI assessments were being destroyed.</p>	<p>Provide evidence that residents' past records are kept for a period of 10 years as outlined in the Health (Retention of Health Information) Regulations 1996.  7 days</p>

<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>	<p>PA Moderate</p>	<p>Regular and prn medications were prescribed and administered correctly. All medication charts had been reviewed by the GP three monthly. There are no standing orders in use. The facility did not have controlled drugs on site. Charts reviewed did not have documented evidence of the effectiveness of the prn medication that was administered.</p>	<p>Medication charts reviewed did not have documented evidence of the effectiveness of PRN medication administered.</p>	<p>Provide evidence that the effectiveness of PRN medication administered is documented after use.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>All files reviewed had initial assessments, InterRAI assessments and long-term care plans developed within 21 days of admission. Lifestyle plans had been evaluated six monthly. Care plan evaluations were completed six monthly when the new care plans were generated. The progress notes did not reflect regular documented review by the registered nurses.</p>	<p>The registered nurses had not reviewed residents progress regularly and document in progress notes.</p>	<p>Provide evidence that the registered nurses document residents' progress and review in progress notes on a regular basis.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Care plans are developed in consultation with the resident/whanau. Information used from assessments, GP medical notes and discharge summaries are used to describe the required support/interventions to meet the resident needs. Four of five lifestyle plans (one hospital and three rest home) did not reflect the resident's current interventions and needs/supports. One resident that identifies as Maori did not have a Maori health care plan in place (link 1.4.1).</p>	<p>Four of five care plans reviewed (dementia level of care) did not reflect the resident's current interventions and needs/supports for the following;</p> <p>(i) four residents with mood and challenging</p>	<p>Provide evidence that care plans reflect the resident's current needs/supports to meet the resident goals.</p>

			<p>behaviours as triggered in the assessment had insufficient interventions addressing management of mood and challenging behaviour, identification of triggers and de-escalation techniques.</p> <p>(ii) two dementia level of care residents with high falls risk as identified in the assessment.</p> <p>(iii) one resident with advancing chronic illness that had urinary incontinence identified.</p>	90 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Files reviewed evidenced that monitoring occurs for weight, vital signs and blood glucose. Three residents post-unwitnessed falls did not have neurological observation completed as per policy. One resident with chest infection did not have a short-term care plan in place.</p>	<p>(i) There was no documented short-term care plan in place for one resident with chest infection.</p> <p>(ii) Neurological observations had not been completed as per policy for three residents with unwitnessed falls.</p>	<p>(i) Provide evidence that care plans are updated as per residents assessed needs.</p> <p>(ii) Provide evidence that neurological observations are completed for unwitnessed falls as per policy.</p> <p>90 days</p>

<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Moderate</p>	<p>Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted. Broken windowpane in one of the bedrooms plus two-bathroom windows had no safety bars in place as they were opening wide. All this was repaired on the audit days reducing any potential risks however the gated back-stairway on the upper floor was not safe for residents. The gated stairway was raised to a safe height after the audit and evidence was sighted.</p>	<p>The gate and the other supporting structure on the stairway were too low for residents' safety.</p>	<p>Provide evidence that the stairway access is safe for residents.</p> <p>90 days</p>
<p>Criterion 1.4.3.1</p> <p>There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.</p>	<p>PA Low</p>	<p>There are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. This includes private ensuites and shared bathrooms. Records of hot water temperatures are maintained to ensure that the water remains at a safe and consistent temperature. Visitor toilets are available throughout the facility. Wall surfaces in most shower/bathing facilities were shrinking and cracking. All this was repaired after the audit and evidence was sighted.</p>	<p>Wall surfaces in most shower/bathing facilities were not consistent with infection control requirements.</p>	<p>Provide evidence that the wall surfaces are repaired and regularly maintained.</p> <p>180 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>PA Low</p>	<p>Cleaning and laundry process are monitored through internal audit programme and corrective actions are acted upon. Care staff demonstrated a sound knowledge of the laundry processes however dirty/clean areas were not clear and handling of soiled linen was not consistent. Signage was put up on the audit days in the laundry indicating clean and dirty areas.</p>	<p>There was no clear demarcation of clean and dirty areas in the laundry.</p>	<p>Provide evidence that there are marked demarcations in the laundry for clean and dirty areas.</p> <p>180 days</p>
<p>Criterion 3.1.1</p>	<p>PA Low</p>	<p>The registered nurse is the designated infection control</p>	<p>The registered nurse did not have a signed</p>	

<p>The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.</p>		<p>person for the service.</p>	<p>appointment letter to the role and an accompanying job description defining lines of accountability.</p>	<p>Provide evidence that a signed appointment letter and job description are in place.</p> <p>180 days</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>PA Low</p>	<p>The infection control nurse collates infection control data and reports to the clinical team leader.</p>	<p>Results of infection control data are not evidenced in minutes of staff meetings.</p>	<p>Provide evidence that infection control data is presented at staff meetings.</p> <p>180 days</p>
<p>Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.</p>	<p>PA Low</p>	<p>The clinical team leader is the designated restraint coordinator for the service.</p>	<p>The clinical team leader is appointed to oversee the restraint role however it was noted that there was no signed appointment letter and job description evidenced on file.</p>	<p>Provide evidence that a signed appointment letter and job description are in place.</p> <p>180 days</p>

## 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.