

Experion Care NZ Limited - Woodfall Lodge Home and Hospital

Introduction

This report records the results of a Provisional 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:

Legal entity:	Experion Care NZ Limited
Premises audited:	Woodfall Lodge Home and Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 July 2019 End date: 26 July 2019
Proposed changes to current services (if any):	Experion Care NZ Limited intends to take ownership of the service on 17 September 2019 depending on the outcome of the provisional audit. Total beds occupied across all premises included in the audit on the first day of the audit: 32

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.

General overview of the audit

Woodfall Lodge can provide care for up to 38 residents and is certified to provide rest home and hospital level care. The care services manager/registered nurse (CSM/RN) has been running the service for over two years reporting to the operations manager/registered nurse (OM/RN), general manager (GM) and board of directors. The management team have experience in the aged care sector. There have been no changes to the facility since the previous audit.

This provisional audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. A change of ownership is anticipated to occur on 17 September 2019 and after approval by HealthCERT through this audit. The prospective owners are in the process of completing the requirements for owning the service. The prospective owner has experience in the health sector and owns four aged care facilities in New Zealand. The prospective provider has no intentions of changing the existing service or the facility should the sale of the service be confirmed.

The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, staff and management and interview with the prospective owner

Improvements are required to the following: service provider availability, adverse events reporting, complaints management, maintenance of the facility, acquiring a suitable van, planned activities and evaluations.

Consumer rights

Staff demonstrated knowledge and practice around respecting residents' rights, in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Informed consent is obtained appropriately, and signed consent forms are in residents' records reviewed.

There are no identified barriers to Maori residents accessing the service. Services are planned to respect individual culture, values and beliefs of all residents. An interpreter and cultural advisors are available if required.

The organisation provides services that reflect current accepted good practice. as seen in policy and procedures for service delivery. Education for staff is encouraged and an annual education plan is in place.

Linkages with family and the community are encouraged and maintained. Family stated that they felt welcome to visit at any time.

The organisation respects and supports the right of the resident to make a complaint. The service has a complaint register.

Organisational management

Kaylexcare (Fielding) Limited is the governing body and is responsible for the services provided. Woodfall Lodge is one of the three facilities owned by the Kaylex Care Group. The service is managed by the care services manager/registered nurse who is appropriately qualified. The business plan documents the organisation's goals and objectives. Effective reporting processes are in place. The organisation's quality and risk management system are used to ensure service delivery is of a consistently high standard. Adverse events are recorded, investigated and reported to staff and the board. Residents' information is managed efficiently, contains a level of detail relevant to the service and meets health record requirements.

Human resource processes support good employment practice. All staff receive an orientation. Ongoing training is provided, and staff competencies are assessed and monitored.

Continuum of service delivery

The nursing team is responsible for the development of care plans with input from residents, staff and family member representatives. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems as they arise. Files sampled demonstrated that the care provided and needs of the residents are reviewed and evaluated in a regular and timely manner.

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

Medicines are safely managed and administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) every three months or when required.

Residents` nutritional requirements are met, special diets catered for and food readily available. The service has a dietician approved four-week, summer/winter menu. Kitchen registration and safe food handling training are up to date.

Safe and appropriate environment

The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to hazardous waste or infectious substance. There are documented emergency management response and security processes which are understood and implemented by staff. Woodfall lodge has adequate supplies of food, water and emergency provisions on hand.

The building has a current building warrant of fitness and an approved fire evacuation plan.

All bedrooms are single occupancy with hand basins in each and were personalised to suit the individual. There are adequate toilet, bathing and hand washing facilities. Lounge and dining areas meet residents' relaxation, activity and dining needs. Residents and family/whānau were happy with the environment provided.

Restraint minimisation and safe practice

The RN is the restraint coordinator. The organisation has policies and procedures that support the minimisation of restraint. Ongoing restraint and challenging behaviour training are provided. There were three residents using restraint and one using an enabler at the time of the audit.

Infection prevention and control

The infection prevention and control management system are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. The required policies and procedures are documented. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

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	44	0	3	3	0	0
Criteria	0	95	0	3	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>The consumer rights policy meets the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). The admission pack which is given to new residents and families was sighted and was well presented with all information required. Posters of the Code are displayed in all service areas.</p> <p>Staff receive training on the Code at commencement of employment as part of the orientation/induction process. Ongoing training is provided annually at staff meetings. The clinical staff interviewed demonstrated knowledge of the Code and its implementation in their day to day practice.</p> <p>The Code is made available in poster and pamphlet form in English and Te Reo Māori and other languages are made available as needed.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>	<p>FA</p>	<p>All resident files sampled contained signed consent forms or have appropriate notes on the residents’ preferences regarding consents.</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>Consents included residents' consent to the collection and sharing of personal information and to allow disclosure of information to family/whanau and other health professionals. Where residents were unable to do so, actions taken by staff to ensure residents understood all aspects of accepting the service were noted in resident's files. A detailed informed consent policy is implemented. Staff interviewed said they promoted residents to write an advance directive.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present. Staff undertake training in advocacy every second year. Family/whanau interviewed reported that they are included in decision making to support their family member and they were provided with information regarding access to independent advocates.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>All residents and family/whānau interviewed stated that the service supports maintaining links with natural supports and taking part in activities in the community. Family/whānau stated they felt welcome and able to visit at any time.</p>
<p>Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>The organisation respects and supports the right of the resident to make a complaint. Woodfall Lodge implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system. During interview, residents, family/whānau and staff reported their understanding of the complaints process and reported any complaints made had been responded to in a timely manner. Staff confirmed they document verbal complaints, so issues are accurately reflected and followed up by the facility manager.</p> <p>Complaints forms were filled in by the staff member receiving the complaint verbally, or in writing and acknowledgment and response to the complainant was seen in complaint records available, however improvement is required regarding the complaints register and complaint documentation.</p>

		Complaints forms are on display and available in the main entrance and included in the information pack given to new residents on arrival. The service also has a suggestion box which is checked regularly, and complaints / feedback can be placed in this at any time.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	<p>A copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family during the admission process.</p> <p>The advocacy policy is available to guide staff who could describe the intention during interview. The policy refers to the complaints procedure and that all residents receiving care within this organisation have appropriate access to an independent advocate, including access to a cultural and/or spiritual advocate whenever required. Training in the Code and national advocacy service is part of orientation and included as a refresher topic.</p> <p>In interview conducted the prospective owner demonstrated a good understanding of the consumers rights (the code) that they must adhered to.</p>
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	<p>The privacy policy requires the privacy and personal space of residents to be respected and observed and that the staff will facilitate the use of private space when meeting family/whanau and visitors. Interviews with residents expressed that they were treated with respect and dignity, privacy maintained, and independence encouraged, and they were happy at the facility.</p> <p>The residents` records reviewed indicated that residents received appropriate services that are responsive to their needs, values and beliefs of culture, religion and ethnicity.</p> <p>The families interviewed reported that their relatives were treated in a manner showing regard to the resident`s dignity, privacy and independence.</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>Guidelines are developed and implemented to ensure guidance is available for the provision of culturally safe services for residents that identify as Māori. The staff interviewed demonstrated good understanding of services that would need to be provided for Māori residents to meet identified needs and the importance of whānau.</p> <p>Woodfall Lodge has a Māori Health Plan which acknowledges the Treaty of Waitangi and states the service will provide an appropriate and effective health service for Māori. Associated policies such as cultural awareness and recognition of individual values and beliefs ensure the service is committed to identifying the needs of the residents and ensuring staff are trained and capable of working appropriately with all residents in their care. The identification and reduction of any barriers are part of the organisation`s Māori Health Plan objectives.</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>The cultural, ethnic, spiritual values and beliefs are recognised and respected by staff and policy and procedures support this. Staff interviewed recognised and respected these cultural needs in their everyday practices, and they received cultural safety training as part of the mandatory training annually.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff records reviewed had employment agreements that had clear guidelines regarding professional boundaries. All staff interviewed had a clear understanding of professional boundaries. Residents and family interviewed said they can choose to participate in the programmes and activities offered. Processes were in place to prevent financial or other exploitation of residents. Personal money can be kept in the office safe or deposited in the Residents trust account with a statement of account provided to the resident or enduring power of attorney every two months.</p> <p>House rules are also part of the employment agreement and staff responsibilities were reviewed. All registered nurses have completed the professional boundaries workshops which is a requirement for the</p>

		New Zealand Nursing Council.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Woodfall Lodge provides a service to residents at hospital or rest home level, in a respectful, dignified and caring fashion. The family/whānau interviewed stated that the service staff work in partnership with the residents to meet their needs and support them to live the best life they can. The service does this by supporting wellness, hope, self-determination and resiliency through planned service delivery. It was confirmed through examples given, resident and family interviews and observations during the audit that the service endeavours to enrich the lives of the residents (e.g. a twin sister joins the resident at lunch each day). All staff interviewed were aware of the individual needs of residents and were observed to accept residents' diversity and employ creative strategies to meet individual needs. Family interviewed stated that the current diversional therapist includes hospital residents in as many activities as possible which has increased interest in daily life.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Staff interviewed understood open disclosure. Residents and families said they have effective and open communication with staff. Resident's files noted that residents and their family/whānau have been informed of any significant events or changes in their lives and support and family interviewed confirmed this. Monthly meetings are held to ensure residents could raise any issues or concerns. Staff knew how to access interpreter services.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The service is for sale and the prospective owner has commissioned a provisional audit. The prospective owner has an established organisational structure outlined in their business plan. The potential owner reported that Woodfall lodge will be under Experion Care NZ Limited which owns other four facilities in New Zealand. The 2018-2019 business plan was sighted and outlined delivered service, objectives and performance measures. Purpose, values, scope, direction and goals of the organisation are documented.</p>

	<p>The transition plan/business plan sighted includes how the prospective owner will be transitioned into the running and management of the service under the support of the current owner. The business plan includes time frames for maintaining the current quality system, policies and procedures, staffing and service delivery. The prospective owner's intention is to retain the current service as is, including all staff. Future changes will be considered on a needs basis and covered in the business plan. The planned settlement date is 17 September 2019. The prospective owner and representatives of the current owner reported that the planned transition time will be for a period of seven weeks onsite and thereafter offsite as needed. All files sampled evidenced that residents are receiving the appropriate level of care.</p> <p>The prospective owner demonstrated a good understanding of the Aged Related Residential Care Agreement (ARRC) and the Health and Disability Services requirements. They also confirmed awareness of the previous audit findings.</p> <p>The organisation is currently privately owned is being run by the care services manager/registered nurse who has been providing general oversight. The CSM/RN is supported by operations manager/registered nurse, general manager and the directors. There are registered nurses (RNs) onsite in all shifts and the operations manager/registered nurse will provide on call cover alternating with another senior RN. All members of the management team are suitably qualified and maintain professional qualifications in management, finance and clinical skills. The CSM/RN had completed professional development activities related to managing a rest home/hospital through Mid-Central Health Board aged residential care quarterly forums. Responsibilities and accountabilities are defined in the job descriptions and individual employment agreements.</p> <p>The service holds contracts with the DHB and the Ministry of Health for ARRC, YPD (young physically disabled), respite and long-term support chronic health conditions. There were 31 residents under the ARRC agreement and one respite resident at the time of the audit. 36 of the rooms have been approved as dual purpose and two rooms for rest home level care only. On the day of the audit there were 10 hospital level care residents, 21 rest home level care residents of which one resident was in for respite care. There were 32 residents receiving</p>
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		services on the day of the audit.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the CSM/RN is absent the operations manager/registered nurse who is a facility manager from another facility will carry out all the required duties under delegated authority supported by the senior registered nurse. Both can take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. Recruitment of the clinical nurse manager, care staff and registered nurses is currently underway. The prospective owner confirmed that after settlement date Experion Care NZ Ltd will have their management and on call roster in place. Other experienced managers from sister facilities will be called in to provide cover and oversight if required.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk 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 surveys, monitoring of outcomes, clinical incidents and accidents including infection control surveillance. Documenting complaints on the complaints register and analysing trends (Refer 1.1.13.3) and an improvement is required regarding signing off and family/whanau notification of adverse events (Refer 1.2.4.3).</p> <p>Meeting minutes sampled confirmed that review and analysis of some quality indicators is completed and that the related information is reported and discussed at the management team meeting 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 and a yearly report is compiled, and this was sighted.</p> <p>Policies 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</p>

		<p>systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. These are managed by an external consultant who keeps the service updated on any recent changes.</p> <p>The risk register is in place and includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risk. Any identified risks are reported to staff and management. The CSM/RN described the process for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The CSM/RN is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The previous area for improvement regarding providing hard copy policies and procedure to staff was addressed.</p> <p>The prospective owner intends to continue with the current quality and risk management programme.</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>PA Low</p>	<p>Policy and procedure detail the required process for reporting incidents and accidents. Staff are provided with education on the responsibilities for reporting and managing accidents and incidents during orientation and during discussions at staff meetings. A sample of reported events demonstrated that incidents are reported promptly, investigated and responded to in a timely manner, however events are closed off at the end of the month, rather than individually, and details for improvements or family/whanau notifications are not all recorded.</p> <p>The recording and coding of events supports the writing of a monthly report showing occurrence and trends which is noted in staff meeting minutes. Some improvements were noted in the summary tabled at staff meetings. Family stated that they were told of incidents and the outcome or change that would be made but this is not recorded.</p> <p>The facility manager, operations manager and the RN / manager can identify the type of events that must be reported to external agencies. An essential notification was made when a resident was diagnosed with a sacral pressure ulcer which required hospitalisation.</p> <p>The prospective owner understands their statutory and/or regulatory</p>

		obligations in relation to essential notification reporting and to notify the correct authority where required.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of employment legislation. Staff files sampled showed comprehensive orientation and annual core training, police and reference checks, one on one supervision and current employment contracts. Professional qualifications are validated, including evidence of registration and scope of practice for staff who require this. Residents and family state that their needs are being met.</p> <p>All staff files sampled had the required qualifications, annual practising certificates and up to date annual or biennial core training. For example, medication management, first aid, infection control, advocacy services, the Code, emergency management and manual handling. All RNs have completed interRAI training and competencies and have cardio pulmonary resuscitation (CPR) training and all care workers have level 3 or 4 NZQA training in aged/dementia care and first aid certificates.</p> <p>Kaylexcare (Fielding) Ltd is actively working with the prospective owner in recruiting new staff as per their agreed arrangement. The shortfall in staff at present is being addressed by Kaylexcare (Fielding) Ltd and Experion Care NZ Ltd and the local district health board is aware. Ongoing recruitment is for a clinical nurse manager, care staff and registered nurses. The new staff being recruited will be on Kaylexcare (Fielding) Ltd contract and will transition to Experion Care contract upon settlement. New staff contracts will be given to all transferring staff two to three weeks prior to settlement date and these will be on similar terms and conditions as with Kaylexcare (Fielding) Ltd. The Operations /Manager/Registered Nurse and a Registered Nurse from Kaylexcare (Fielding) Ltd will provide cover until the settlement date supported by the Facility Manager from another service owned by the prospective owner.</p> <p>All previous areas requiring improvement were addressed.</p>

<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Moderate</p>	<p>A policy details staffing levels and skill mix requirements, and this aligns with the requirements of the provider's contract, however an improvement is required to ensure that the required allocation of staff is provided.</p> <p>The current roster was reviewed and demonstrated that there is a RN on duty 24 hours a day, seven days a week. Healthcare assistants work a variety of shifts, with start and finish times varied depending on the needs of residents and facility occupancy.</p> <p>The facility manager, care services manager/registered nurse (CSM/RN), receptionist / administrator, Diversional Therapist (DT), and maintenance person are on site weekdays, and any clinical hours are additional to the rostered RN hours.</p> <p>Additional staff hours are rostered for the cook and kitchen hand, and cleaning / laundry services every day including weekends.</p> <p>The staff confirmed the facility manager is available out of hours if required. The diversional therapist (DT), activities coordinator has a current first aid certificate as required to take residents off site. Residents and family members interviewed confirmed that staffing numbers have been low, and some are working extra shifts. All residents and family interviewed stated that health care assistants (HCA) were kind, dedicated and helpful.</p> <p>The prospective owner and Kaylex Care Group are in the process of recruiting staff to cover gaps of those resigned and the local district health board is aware of this arrangement.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Resident information is collected and stored in accordance with the New Zealand Health Records Standard. A resident file is created prior to admission and essential information is entered on the day of admission. For example, medical conditions, medicines, next of kin and emergency contact numbers, initial assessments and the referral information). The front sheet of the record contains the unique</p>

		<p>personal identifying information, such as the resident's national health index number (NHI), date of birth, legal name, preferred name, past medical history, presenting medical and physical conditions, allergies/sensitivities, current GP, ethnicity, current support needs levels and gender.</p> <p>The current resident records are filed in the two reception areas in filing cabinets which are locked when not in use or unattended. Archived records of past and deceased residents are stored in a secure place.</p> <p>The residents' records sampled demonstrated that entries were legible, and the writer of each entry signed their name, initials and designation. Records were integrated with information from all disciplines and external providers.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements were signed in all residents' sampled records. Residents and families reported that the admission agreements were discussed with them in detail by the staff and smooth entry with family support was achieved.</p> <p>The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement. All residents had the appropriate needs assessments prior to admission 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>There are policies to describe guidelines for death, discharge, transfer, documentation and follow-up. A record is kept, and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The residents and their families were involved for all exit or discharges to and from the service. The CSM/RN stated that telephone handovers are conducted for all transfers to other providers.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic medication system was observed on the day of audit. Three monthly medicine reviews are completed by the GP. Discontinued medications are indicated and were noted on the electronic medication system. Indications for use are noted on 'as required' medications, allergies are clearly documented, and photos are current.</p> <p>The RN was observed administering medications safely and correctly. The medication and associated documentation are stored safely, and medication reconciliation is conducted by RNs when a resident is transferred back to service. The RNs checks medications against the prescription and all medicines sighted were within current use by dates. Expired medications are returned to the pharmacy in a timely manner. There were no residents self-administering medications. Self-medication administration policies and procedures are in place. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted, and all medications are stored appropriately. The previous identified area of improvement regarding administration of controlled medications was addressed.</p> <p>The staff interviewed 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>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 at Woodfall Lodge is provided on site by two cooks. The previous corrective action regarding food safety training has been addressed. Staff involved with food preparation and cooking have completed food safety training. The menu has also been reviewed this year to verify it meets recognised nutritional guidelines for older people. A food control plan is in place and was registered 29 May 2018 with the Care Association New Zealand Food Control Plan. A kitchen registration was sighted.</p> <p>All aspects of food procurement, production, preparation, storage,</p>

		<p>transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan.</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. 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. Any areas of dissatisfaction were promptly responded to. The facility has three dining rooms, in which residents were seen to be given time to eat their meal in an unhurried fashion. Those residents requiring assistance had this provided, by staff.</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>All referrals are supported by a Needs Assessment and Service Coordination service (NASC) member. In the event a person is declined, then possible alternatives are suggested to the person facilitating the referral. If the client has been referred by a third party, it is expected the referrer will advise the client either verbally or in writing of the reason for this and what alternative services may be available. This is noted on the bed vacancy enquiry form. The reason for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</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>Initial assessments are completed within the required time frames. Identified triggers are addressed in the care plans. Assessments and care plans include input from the family/whānau and other health team members as appropriate. The RNs utilise standardised risk assessment tools on admission. In interviews, residents and relatives expressed satisfaction with the assessment process.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans are resident focussed, integrated and provide continuity of service delivery. The outcomes of assessments are used to inform long term care plans, and short-term care plans are developed for acute needs as required. Goals and interventions are developed to address the identified needs. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the wound specialist nurses, podiatrist and physiotherapists. Residents and relatives interviewed reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents met assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed as per policy. Monthly observations are completed and were up to date. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs. Staff confirmed they have access to the supplies and products they needed.</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 Moderate</p>	<p>The activities programme is provided by a diversional therapist, working five days a week. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. The programme ensures resident's individual cultural needs are recognised. The residents have opportunities to maintain interests they have developed within their lifetime and to develop new friendships.</p> <p>The weekly plan is available and displayed. All residents receive a copy. The diversional therapist reported that the programme gives the residents a sense of purpose, belonging and meaningful activities reflecting normal life interests. An improvement is required regarding the development of individual activity plans.</p> <p>The service provides easy access to safe outside areas. Woodfall Lodge is located close to the local shopping centre and residents are</p>

		<p>within easy walking distance of a range of community activities. Residents interviewed confirmed they find the activity programme meets their needs, other than the difficulty getting out due to difficulty accessing the van. This was a previously identified area for improvement which is yet to be remedied.</p> <p>A daily attendance record is maintained and reviewed by the diversional therapist. Where possible residents' independence is encouraged to maintain links with family and community groups. Families are encouraged to attend activities. Families interviewed take their relative to religious events and social events weekly.</p> <p>The family/whanau interviews reflected that their relative enjoys the range and variety of planned activities. One family member noted that the DT has included the hospital level residents more frequently which has increased her relatives' interest in life.</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>Significant changes are noted, and care plans are updated when required. Relatives and staff input are sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed, signed, and closed out when the short-term problem has resolved. An improvement is required regarding the evaluation of activity plans.</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>There is a documented process for the management of all referrals. Residents are supported to access or seek referral to other health and/or disability service providers of their choice. The service utilises a standard referral form when referring residents to other service providers. Copies of referrals were sighted in residents' files sampled. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Residents and family are kept informed of the referrals made by the service. All referrals are facilitated by the RNs or GP.</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>Policies were sighted which detailed how waste was to be segregated and disposed and were implemented. The policy content aligns with current accepted practice. There is a spill kit on site.</p> <p>Appropriate personal protective equipment (PPE) was available on site including disposable gloves, aprons, masks, and face protection.</p> <p>An emergency kit with PPE is also available for use in an outbreak or other significant event. The staff interviewed on this topic detailed what PPE was required to be worn by staff and when, in order to minimise risk of exposure to blood and other body fluids and contaminated items/equipment. Staff confirmed any exposure to hazardous substances (chemicals, blood, body fluids) would be reported as an incident.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. Handrails are installed in corridors, showers and toilets. The physical environment minimises the risk of falls and promotes safe mobility and independence by ensuring the flooring is appropriate and secure, bathroom floors are non-slip, and walking areas are not cluttered.</p> <p>There is a current building warrant of fitness (BWOFF) with an expiry May 2020. An external company undertakes performance monitoring and electrical safety checking. (where applicable) of clinical equipment. Electrical and clinical equipment sighted had evidence of current testing and tagging. Maintenance requests are identified and documented by staff when issues are noted. Requested tasks have been signed off as completed or are in progress. The facility vehicle has a current registration and warrant of fitness.</p> <p>Residents were observed to be mobilising independently or with the use of a mobility device in their bedrooms and in communal areas. There are several external furnished decks and outside areas that residents and family can use. Staff identified these areas are used more by residents during the warmer months. Hot water temperatures are recorded regularly and were at or below the recommended maximum of 45° (degrees). The carpet in the Makino lounge and upper</p>

		<p>hallway is worn and wrinkled in places. The previous identified areas requiring improvement regarding checking of hot water temperatures, reconfiguring the layout to allow for clear lines between clean and dirty flows and repairing the bathroom floor were addressed.</p> <p>The prospective owner reported that there are no immediate plans for environmental changes to the service but should this be required in future it will comply with legal requirements.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All bedrooms have a hand basin. Hand gel is also available for staff and residents at locations around the facility.</p> <p>There are six toilet /showers and five separate toilets that all residents can access. Residents stated that there are adequate bathroom and shower facilities for their use, and that staff assist or provide supervision when showering if required. Occupied / vacant signs are present on the bathroom and shower doors. There are separate toilet facilities for staff use.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are 38 single occupancy bedrooms, ten bedrooms and one respite bedroom are hospital level. The rooms contain space for personal possessions and use of mobility devices if required. Residents were sighted mobilising inside the rest home independently, including while using a mobility aid. Residents assessed as hospital level have required hospital beds in place.</p> <p>The staff interviewed advised there is normally enough space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this.</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>There are two lounges, a sunroom and three separate dining areas that residents and their family or visitors can use. The residents and family members interviewed confirmed that there is enough space available for residents and support persons to use in addition to the residents' bedrooms.</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>	<p>FA</p>	<p>All cleaning and laundry services are carried out by the housekeeper on roster. Policies and wall mounted posters detail how the cleaning and laundry services are to be provided. Resident's personal clothing is washed and returned daily. The housekeeper on duty during the audit could identify correct procedures, separate areas for clean and dirty items, use of chemicals and describe tasks to be undertaken daily, weekly and monthly.</p> <p>The residents and family members interviewed confirmed the rest home is kept clean and tidy and residents' laundry is washed and returned in a timely manner.</p> <p>Internal audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated compliance with most aspects of the service requirements and remedial action where improvements were requested / identified. The resident satisfaction survey includes questions related to environmental cleanliness and laundry services.</p> <p>Chemicals are stored in designated secure cupboards or in the sluice room. The wall mounted auto chemical dispenser is in the laundry. Instructions for managing emergency exposures to chemicals is readily available to staff. The chemical supplier monitors the chemical dilutions monthly and assesses aspects of quality and provides written reports.</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>The fire evacuation plan has been approved by the New Zealand Fire Service (NZFS) in a letter dated 21 August 2002. The most recent fire evacuation drill (6 monthly) was conducted in June 2019 and the records were sighted.</p> <p>Policy documents provide guidance for staff on responding to other events, including (but not limited to) earthquake, flooding and volcanic eruptions. The current document is available for staff on the computer and as a hard copy on the staffroom notice board.</p> <p>Staff interviewed detailed their responsibilities in the event of emergency and training they have completed.</p>

		<p>There are enough supplies available of dry food, lighting, a radio and batteries, and other clinical supplies for use in emergency. A BBQ for cooking is available along with spare blankets. A large water tank is onsite that refills with fresh water for use in emergency. Emergency lighting is available.</p> <p>Call bells are present in the bathrooms and residents' bedrooms. They alert audibly and a light also illuminates outside the room. Three call bells tested at random were fully functioning. Staff were observed to answer the call bells promptly.</p> <p>The external doors and windows are checked and locked prior to dark. All external windows and doors are also checked and secured at this time, unless the resident wants their bedroom window left open. A door bell is present at the front entrance for family / visitors to ring after this time in order to gain access. No residents or family expressed any concerns about security in interview, annual surveys nor in resident meeting minutes reviewed.</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 have a window which allows adequate natural light and safe ventilation, some also have a door onto a deck. Heating is centralised via underfloor or ducted heating depending on the area. Residents and family members interviewed verified the facility is suitably warm and ventilated. Smoking is only allowed in one designated external area.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Woodfall Lodge provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The CSM/RN is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections</p>

		<p>through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</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 ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</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 organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.</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>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included the GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</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>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</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>There is a restraint minimisation policy. The service actively works to minimise the use of restraint. Definitions of restraint and enablers are consistent with the standard. Residents are supported in maintaining and promoting independence and safety. Records sampled confirmed that staff receive ongoing education on restraint/enabler and challenging behaviour. A restraint committee is in place. There were three residents using restraint and one using an enabler on the day of the audit. The assessment, approval, monitoring and review process is the same for both restraints and enablers.</p> <p>In interview conducted the prospective owner demonstrated a good understanding of responsibilities in respect of restraint minimisation and safe practice.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint coordinator is a registered nurse. The coordinator is supported by the CSM/RN regarding restraint practice and quality and risk considerations. The role of the coordinator is documented. The use of all restraints and enablers is provided in reports to the operational management team.</p> <p>The use of restraint is approved by the clinical team and includes the family and GP. The approval process is comprehensive and requires a full assessment of risk and evidence of trialed alternatives. The required approval was sighted in restraint records sampled.</p>

		Approved equipment which can be used as a restraint includes bed rails and lap belts.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	The restraint assessment process is fully documented and includes the requirements of this standard. Resident records sampled confirmed completed assessments and approval. Assessments and approval were signed by the resident (or family), the GP and the restraint coordinator. The assessment identified the cause, alternatives, risk, cultural considerations and outcomes. The most common reason for implementing a restraint in the records sampled was for safety reasons.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	All restraints are used as a last resort. Discussions regarding trialled alternatives were sighted in records sampled. Restraints in place are monitored for safety. Bed rails have protective covers and lap belts are monitored for safety. All residents using lap belts as restraint/enabler are monitored every two hours, with a two-hourly release. The restraint coordinator maintains a log of all restraint use, including evidence of two hourly checks. There have been no reported incidents related to unsafe restraint use. Restraints were observed to be in safe use during the audit.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	Regular reviews are conducted on residents with restraints and this was evident in the records sampled. The GP confirmed involvement in the restraint review process. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, enough monitoring and any change required. Interviewed staff and family/whanau confirmed involvement in restraint use evaluations. The evaluation forms included the effectiveness of the restraint in use and the risk management plans documentation in the long-term care plans. Evaluations time frames are determined by the risk levels.

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service has demonstrated monitoring and quality review on the use of restraints. Restraint updates are included in the monthly staff meetings and continuous quality improvement summary reports. Individual approved restraints are evaluated three monthly through a restraint meeting and as part of the facility approval team review with family/whanau involvement. The RN reported that assessments and monitoring are appropriate. Policies and procedures are up to date and a training record was sighted and annual reviews are completed.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA Moderate</p>	<p>Complaints were sampled. Not all complaints had been entered onto the register. Some complaints did not have any related records on file. There was insufficient evidence that trend analysis for complaints was being completed. An improvement regarding the analysis of complaints is documented in standard 1.2.3. .</p>	<p>Documentation does not match the list of complaints on the register.</p>	<p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> <p>60 days</p>
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where</p>	<p>PA Low</p>	<p>The reporting, investigation and analysing of adverse or unplanned events is thorough. Improvements are noted when a pattern is identified, however not all event records showed the action taken, none had close off dates nor showed if relatives had been notified, however the auditor was told</p>	<p>There was no documented evidence that family notifications were routinely made following an adverse event. or that improvements or changes made as required. Close off dates for each incident or adverse event were also not routinely</p>	<p>Review the process for managing incidents and adverse events to ensure that the required information is documented, and records are maintained.</p>

required.		by relatives that they are kept informed and that improvements are made after an event. This is identified as a records management issue.	recorded.	180 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Moderate	<p>A review of six-weeks paid rosters showed that staff numbers have not met the rostered allocation on day and evening shifts across the reviewed period and staff interviewed stated that this has become a problem. Staff stated that the low shift numbers had been a recent issue, and this was confirmed by reviewing the rosters and with family interviews. Agency staff are not used which resulted in those staff available doing double shifts or extra days. This has not resulted in an increase in adverse events to date, however residents, family and staff stated that they were concerned that the demand to work extra shifts would result in more staff being unavailable. No contingency plan had been put in place.</p>	Not all shifts have had the level of staff stated on the roster.	<p>Ensure the staffing levels and skill mix meet the requirements of the Mid Central DHB providers contract and that a plan is developed to replace staff unable to work.</p> <p>60 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Moderate	<p>Activities plans were not aligned to interRAI assessments and long-term care plans (Refer 1.3.8.2). Activities are planned and provided to develop and maintain residents' interests, strengths and skills. Residents and family interviewed, observations and satisfaction surveys confirmed they find the programme meets their needs. Residents are restricted from going on</p>	Residents have difficulty going on outings due to the van being inaccessible to several residents. The current van only has seating for six residents and access up and into the van is difficult for some residents.	<p>Address the need for transporting residents for activities in the community.</p> <p>60 days</p>

		outings due to the limitations imposed by the Woodfall Lodge van. The van is inaccessible to 15 of Woodfall's residents. The van is a six-seater van, with a low roof and high step, that requires residents to be mobile to get into it.		
<p>Criterion 1.3.8.2</p> <p>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.</p>	PA Low	Residents' long-term care plans and interRAI assessments are being evaluated within the required timeframes, however activity plan evaluations are not occurring at the same time with other care plans and assessments.	Activity plans are not aligned with interRAI assessments and long-term care plans.	<p>Provide evidence that evaluation/reviewing of activity plans is occurring at the same time with InterRAI assessments and long-term care plans.</p> <p>180 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>	PA Low	The flooring was in an acceptable condition in Bowen, and Rimu, with an area in Makino hallway and lounge worn and wrinkled	Worn and wrinkled carpet in Makino lounge and hallway needs rectifying to prevent tripping.	<p>Make carpet in Makino lounge and hallway safe and fit for purpose.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.