

Villages of New Zealand (Pakuranga) Limited - Park Rest Home

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Villages of New Zealand (Pakuranga) Limited

Premises audited: Park Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 16 July 2019 End date: 17 July 2019

Proposed changes to current services (if any): Reconfiguration of services for 39 of 40 beds for dual purpose services (rest home and hospital). Room 461 is to remain rest home only. Geriatric and medical services are to be added to the certificate.

Total beds occupied across all premises included in the audit on the first day of the audit: 35

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Park Rest Home is owned and operated by Real Living Group which owns four facilities. The facility was purpose built as part of Pakuranga Park Village in 1993 and is privately owned. The home provides rest home level care to a maximum of 40 occupants. The village manager and the clinical manager were available for this audit and both are experienced in this sector. Only the care facility is covered in this audit.

This certification audit and partial provisional audit (to change 39 of the 40 beds to dual purpose beds) was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, interviews with residents, family members, managers, staff and a general practitioner.

The manager reported there have been no changes to size or scope of the service since the previous audit.

There were two areas identified as requiring improvement, one in relation to medication management and one in relation to education for staff working in the kitchen. One additional area requiring improvement was for the partial provisional audit relating to increase in staff coverage.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services that are 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 confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori will have their needs met in a manner that respects their cultural values and beliefs. 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.

The complaints management system is effective. Complaints are resolved promptly and effectively. A complaints register is maintained. Residents and their families were well informed about how to raise concerns. The manager advised there have been no external complaints received since the previous audit.

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 low risk.
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Business and quality plans include the scope, objectives, values and direction of the organisation. The organisation has well established quality and risk management systems which monitor service performance. This occurs through internal audits, analysing quality data gathered from event reporting such as incidents, restraints and infections and through resident and relative feedback. Where these activities identify that improvements are required, managers and staff determine the best course of action to resolve the matter. Any gaps in service delivery are monitored by re-auditing to test that improvement has occurred.

Monitoring of the service provided to the governing body is regular and effective. An experienced village manager oversees the facility and is supported by the clinical manager.

All incidents and accidents are reported verbally and in written form. These are reviewed and investigated for cause by the clinical manager who oversees clinical care in the facility. Staff act in an open and frank manner by acknowledging what has occurred and notifying senior staff, families or the GP depending on the nature of the incident as soon as practicable. The clinical manager understands essential notification requirements to agencies such as the Ministry of Health and the DHB.

The service recruits and manages staff using good employment practices. There is a dedicated workforce who are supported to carry out their roles by in service training and industry education in the provision of safe and appropriate care, cleaning and laundry services.

The number of registered nurses, care staff and allied staff on duty for each shift meets safe staffing guidelines and the contract requirements for the level of care provided. A total of four registered nurses (RNs) including the clinical manager are employed to oversee clinical care and there is always an RN on in the daytime and on-call after hours.

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

Continuum of service delivery

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

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

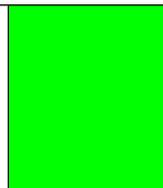
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

Nutritional meals, snacks and fluids are provided in line with recognised nutritional guidelines. Special dietary requirements are catered for. Residents verified satisfaction with meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

Waste and hazardous materials are managed safely. The interior and exterior of the facility is well maintained by a full time employed maintenance person who ensures the buildings and chattels are safe. A current building warrant of fitness was on display. Medical and electrical equipment is tested and serviced regularly. Fire suppression systems are in place and checked as functional by an external contractor. Staff are trained in managing emergencies including attending trial fire evacuations.

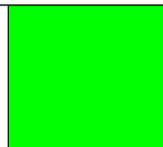
Residents' bedrooms, bathrooms and communal areas used for dining and recreation are spacious and comfortable. Chattels are of a good quality and the furniture provided is suitable for use by older people.

All areas are cleaned daily to a high standard. Laundry services are effective and hygienic.

The home is maintained at a warm and comfortable temperature. All areas have opening doors and windows for ventilation.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Three residents were using restraints at the time of audit. There was no use of enablers.

Staff demonstrated in depth knowledge and understanding about the requirements for this standard. Safe practice related to restraint is occurring. Effective procedures for assessment, approval, monitoring and regular review of restraints are implemented.

Infection prevention and control

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

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	42	0	2	1	0	0
Criteria	0	90	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Park Rest Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed confirmed 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.
Standard 1.1.11: Advocacy And	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were displayed and

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>available in the facility. Interviewed family members and residents were aware of the Advocacy Service, how to access this and their right to have support persons. Interviewed staff provided examples of the involvement of Advocacy Services in relation to residents' meetings and involvement of residents' support persons in care planning and care provision.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and procedures meet the requirements of this standard, the provider's contract with the DHB, and Right 10 of the Code. It also contains references to advocacy and the organisation's quality system, resident's rights, advocacy and resident/family meetings policies.</p> <p>Review of the complaints register and interview with the manager confirmed there have been no complaints received and managed since the previous audit. There have also been no complaints received from external sources such as the Ministry of Health (MoH) or Health and Disability Commissioner or other agencies.</p> <p>Systems are in place to ensure residents and their families are advised on entry to the facility of the complaint processes and the Code. The residents and relatives interviewed demonstrated an understanding and awareness of complaint processes. Staff attend regular education on the Code of Rights, including the complaints processes. Review of residents' meeting minutes provided evidence of discussion on the Code of Rights and complaints.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and during discussion with nursing staff on admission. This was confirmed in general consent forms sighted in reviewed residents' files. The Code is displayed on notice boards around the facility together with information on advocacy services, how to make a complaint and feedback forms. Representatives from Advocacy Services visit the facility every six months and take part in their six-monthly residents' meeting.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have their own room.</p> <p>Residents are encouraged to maintain their independence by having access to participate in community activities and arranging their own visits outside the facility. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Interviewed staff demonstrated understanding of 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. Training documentation was sighted in the staff records that were reviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is a current Maori health plan in place in relation to the Treaty of Waitangi, Tikanga guidelines and access to Maori advice. Maori residents' rights to practice their cultural values and beliefs while receiving services is acknowledged and facilitated by the service provider as required. The service acknowledges the importance of whanau/family involvement in the provision of care as reported by interviewed staff. Guidance on tikanga best practice is available and accessible to staff. There were no residents who identify as Maori on the days of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences required interventions and special needs were identified on admission and are included in the care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries and the Code of Conduct. Records of completion of the</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		required training on professional boundaries and Code of conduct were sighted in reviewed staff files. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals (e.g., the diabetes nurse) and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Education records were sighted in staff files reviewed.</p> <p>Other examples of good practice observed during the audit included staff demonstrating awareness of how to access information as required, for example accessing policies and procedures. Ongoing supervision is provided for staff by the RNs and the clinical manager (CM) and support is sought or provided as required. The local district health board supports the service when required.</p> <p>There are incident reporting systems in place that are linked to open disclosure. Interviewed family confirmed that they are advised of any incidents and accidents promptly and in an appropriate manner.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's health status, were advised in a timely manner about outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services if required, although reported this was rarely required due to all residents able to speak English.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	<p>The business plan/quality plan is developed and implemented. The business plan outlines the purpose, the mission statement, values and scope of business. Goals and objectives are documented. The plan is realistic, achievable and workable for the size of this service.</p> <p>The Park Rest Home is owned and managed by a Trust, the Trustee of which is Villages New Zealand (Pakuranga) Limited. Park Rest Home was opened in 1993 and is licenced for 40 beds (rest home</p>

<p>consumers.</p>		<p>level care). Respite care is provided. A dispensation was approved 24 June 2019 by the Ministry of Health (MoH) to provide hospital level care for one resident; however, the resident has since deceased. The village manager is responsible for the management of the facility and services provided. The village manager reports monthly to the operations manager who reports to the Board of Directors. The day to day operations are overseen by a clinical manager who is a registered nurse (RN) with a current practising certificate. Staff meetings are held monthly and the monthly meeting form and agenda were reviewed.</p> <p>The clinical manager has been in the role since August 2018 and has work experience in the aged care sector and attends industry specific training to maintain the skills and knowledge required for the ARCC. The clinical manager oversees the care provided to residents with the assistance of two senior registered nurses who work full time and one registered nurse who works point four and is casual and on RN who is employed as casual for interRAI. The registered nurses oversee the care staff.</p> <p>Maximum occupancy is for 40 residents and there were 35 residents on the days of the audit, all rest home level care receiving services under the age residential care contract (ARCC) with the Counties Manukau District Health Board (CMDHB). All residents were over the age of 65 years and had signed admission agreements.</p> <p>Partial provisional: The village manager and clinical manager interviewed in regard to the reconfiguration of the service to have 39 dual purpose beds, stated this reconfiguration had been discussed at governance level in anticipation of this audit and approval by HealthCERT. One room only (room 461) is not suitable for hospital level care residents due to design and size of the room.</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 village manager is absent the clinical manager is available to cover and is able to carry out all required duties under delegated authority. During absences of the clinical manager, the clinical management is overseen by one of the two senior registered nurses who are experienced in the sector and are able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>Partial provisional: The coverage if the village manager when absent remains unchanged. The clinical manger would be available to perform all required duties as required for this residential care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities (the audit schedule was reviewed), monitoring of outcomes, and clinical incidents including any infections. Quality</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>and risk activities were integrated and co-ordinated.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality/staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. In other areas of day to day service delivery, corrective action plans were developed where the need for service improvements were identified and are reported at the quality committee meetings. The meeting minutes confirmed that actions were monitored for implementation and effectiveness before being closed off. A monthly narrative and statistical report on quality and risk matters was confirmed by sighting the minutes of meetings. Minutes from staff meetings showed that discussion and reporting on incidents, infections, safety and restraint matters occurs. All staff interviewed clearly understood the service approach to quality and risk.</p> <p>Risk management and occupational health and safety processes were clearly described. The risk management plan was updated annually and identifies all actual and potential business and environmental risks. The sighted hazard register was being maintained and regular environmental inspections were occurring. Residents were being regularly risk assessed using a range of assessment tools including the interRAI assessment tool. The planning and preparedness for emergencies was reviewed.</p> <p>Review of policies and procedures confirmed that policy documents were current and cite best practice. The documents are reviewed annually or earlier if required and are controlled in ways to ensure that only the most up to date version is available. Obsolete documents are managed appropriately. A quality system index is maintained, and manuals are available to guide staff. All new documents are reviewed and authorised by the village manager.</p> <p>Staff are provided with regular education of health and safety matters and are supported in the workplace to keep themselves free from injury. The clinical manager is familiar with the Health and Safety at Work Act (2015) and has implemented the requirements. There had been no staff injuries that required reporting to Worksafe NZ.</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</p>	<p>FA</p>	<p>The adverse event reporting system was a planned and co-ordinated process. Staff document all adverse, unplanned or untoward events on incident forms. These were reported verbally at handover and in the written summary. Incidents are reviewed by the clinical manager who documents follow up actions. A summary of categorised events is submitted to the village manager who reports these to the board monthly.</p> <p>There was evidence in the sample of records reviewed and by interviews that the GP and staff understand and implement open disclosure practices by acknowledging and notifying events to all</p>

<p>their family/whānau of choice in an open manner.</p>		<p>relevant parties (for example, relatives and the GP).</p> <p>The clinical manager described essential notification reporting requirements including for any pressure injuries. The clinical manager stated there have been no significant events that have required notifications to be made to appropriate agencies since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies and guidelines for recruitment and staff management comply with legislation and good employment practices. Professional qualifications are validated before commencement of employment. Copies of the RN's current practising certificates were seen on files. New staff were being recruited according to good employment practices which includes formal interviews, police checking and referee checks. Evidence was sighted in all seven personnel records reviewed. The clinical manager has developed and implemented a schedule (sighted) to ensure all appraisals are completed annually as required by the ARC contract.</p> <p>Each new staff member engages in a comprehensive orientation programme specific to their role. The programme includes mandatory training and competency assessments in emergency systems.</p> <p>Staff learning and development is planned by the clinical manager. Learning and development 2019 was reviewed. In-service sessions on a range of different topics are scheduled over the year and individual attendance and achievements are documented. All staff completed first aid and cardio-pulmonary resuscitation on the 20 February 2019. A running record of training attended and the educational level of each caregiver is recorded. One of the two activities coordinators is a diversional therapist and has completed level 4. All care staff are experienced and have completed a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the CMDHB. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training. Staff who are authorised to administer medicines were being competency assessed annually.</p> <p>Two of four RN's including the clinical manager employed are certified to complete interRAI assessments and are maintaining their annual competency with this. The second permanent RN is enrolled currently to complete the interRAI training.</p> <p>Partial provisional: Staff will continue to be recruited according to Park Rest Home employment practices which includes formal interviews, police checking and referee checks as applicable. Orientation packs are prepared in readiness by the clinical manager. The education plan reviewed covers all clinical topics required for provision of both rest home and hospital level care.</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>The staff availability policy describes the service approach to staffing to provide safe service delivery 24 hours a day seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Observation and review of rosters confirmed adequate cover has been provided with staff replaced in any unplanned absences. All staff have been trained in first aid as per the training records.</p> <p>The sample of rosters for 2019, and interviews with the clinical manager (who develops the rosters), clinical and care staff, residents and families, confirmed there were sufficient numbers of staff on each duty to meet residents' needs. RNs and carers said they are offered extra hours when residents' needs change. The clinical manager works Monday to Friday and there is a registered nurse on each floor 7.30am until 3.30pm (the service operates on two levels with twenty rooms on each floor). On Saturday and Sunday there is only one registered nurse on duty 7.30am to 3.30pm shift. The clinical manager is transitioning to having a registered nurse on the afternoon shifts. There are adequate care staff allocated to cover the number of residents on each shift. A specific staff member is allocated to respond to any village call bells. This still ensures adequate coverage on the care floor and meets the contractual requirements.</p> <p>Partial provisional: The village manager and the clinical manager interviewed stated that if dual purpose beds are authorised the care staffing level would be increased accordingly and with resident acuity considered. In addition to this, there will be an RN on all shifts which is a requirement for hospital level care residents. An advertisement has already been placed to cover the afternoon shift daily to increase the coverage of registered nurses as needed on all shifts.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical records were current and integrated with general practitioner and allied health service provider records. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using an appropriate archiving system. Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum</p>

		electronic database. Records were legible with the name and designation of the person making the entry identifiable.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</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>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, by the RNs and the clinical manager. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes, documentation sighted in reviewed files. Family of a resident interviewed reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The staff observed administering medicines 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. Current medication administration competencies were sighted for all staff who administer medication.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription when medication is received from the pharmacy. All medications sighted were within current use by dates. The service is in the process of changing the medication management system from paper based to electronic system. Staff training for the new system has been scheduled.</p> <p>There were no controlled drugs stored on site on the days of the audit. Interviewed staff demonstrated knowledge on controlled drugs management and storage requirements and are guided by the</p>

		<p>medication management policies and procedures when required.</p> <p>The required three-monthly medication review is consistently recorded on the medicine chart by the GP. On the reviewed medication charts, dates were recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met.</p> <p>There was one resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> <p>An improvement is required in the management of warfarin prescription and administration process.</p> <p>Partial provisional: The clinical manager is fully informed in regard to the registered nurses being on duty every shift with hospital level care residents and stated only registered nurses will administer the medications. The clinical manager and registered nurses interviewed are fully informed of the medication responsibilities for any hospital level residents. The current registered nurses have completed medication competencies and senior care staff for medicine checkers.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The food service is provided on site by a qualified chef and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows a six weekly cycle pattern. The service has contracted two dieticians recently.</p> <p>Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the food safety plan. The chef has undertaken a safe food handling qualification.</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. Food allergies are documented and included in the care plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>An improvement is required to ensure all kitchen assistants have completed relevant food hygiene training.</p> <p>Partial provisional: Current food services are appropriate for the planned increase in acuity of residents at hospital level.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring was discussed with the clinical manager. There is a clause in the admission agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, pressure risk and interRAI assessment, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by two trained interRAI registered nurses (RNs) on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is implemented in a timely manner. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. Interviewed residents and families confirmed satisfaction with the care provided.</p>
<p>Standard 1.3.7: Planned Activities</p>	FA	<p>The activities programme is provided by an activities coordinator and activities assistant who is a</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>diversional therapist (DT) having completed the training for the National Certificate in Diversional Therapy.</p> <p>Social assessment and history are conducted on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly and as part of the formal six monthly interRAI and care plan review. A follow up is completed with residents, if changes in activities participation is identified and review implemented to capture the residents' current abilities and interests.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes by the care staff. If any change is noted, it is reported to the RNs. The RNs review and document in the progress notes when there is need or changes in residents' condition and weekly as a minimum.</p> <p>Care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessments, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated for acute infections and wounds in the reviewed files. Unresolved problems were added to the long- term care plans after three weeks. Residents and families/whānau interviewed confirmed involvement in evaluation of progress and any resulting changes. Short term care plans were closed off when the short-term problems resolved.</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. The service has one GP who is contracted to oversee medical care for all residents. If the need for other medical services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files reviewed, including documentation from other specialist services where residents were referred to. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute or urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Policy and procedures contained clear descriptions about disposal methods for all types of hazardous and domestic waste. These included standards about chemical labelling, the use of protective clothing and equipment and reporting of spills incidents. Sluice rooms were observed to be in a tidy and hygienic condition. Chemical Material Safety Data sheets were available and readily accessible to staff in a number of locations. The hazard register was current.</p> <p>Review of staff training records and interviews with staff who carry out cleaning and laundry duties confirmed that regular training and education on the safe and appropriate handling of chemicals and waste occurs. Visual inspection throughout the facility and observations of staff during both audit days revealed that protective clothing and equipment (for example, gloves, plastic aprons, footwear, and masks) was provided. Additional stores are readily available if and when required.</p> <p>All chemicals were being stored securely and decanted into clearly labelled containers. The chemical supply company visits each month to check the effectiveness of their products and to support staff with correct handling and use of chemicals.</p> <p>Partial provisional: No additional changes will be required with the dual purpose beds.</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>FA</p>	<p>The physical environment was safe and fit for purpose and well maintained. Handrails were installed in corridors, showers and toilets to promote safe mobilisation.</p> <p>All external areas inspected were safe and surfaces with paving were level. Shaded areas were positioned near the bowling green with appropriate seating for older persons.</p> <p>All areas of the facility were maintained in very good repair. Medical equipment such as sphygmomanometer, oxygen concentrator, ear syringe, floor and chair scales, thermoscan, charging transformer and other equipment were checked and calibrated annually. A standing/transfer hoist has been purchased suitable for rest home and hospital level care residents and training for staff has been provided. The biomedical equipment performance verification report was reviewed dated 8 April 2019 and next due April 2020. The lift was between the two levels of the rest home was checked on a regular basis and the warrant of fitness was displayed in the lift.</p> <p>Staff and residents confirmed they knew the processes they should follow if any repairs or maintenance is required. Any request are appropriately actioned by the maintenance personal interviewed.</p> <p>The current Building Warrant of Fitness expires on 4 April 2020 and is framed and displayed at the entrance to the village and the rest home.</p> <p>Partial provisional: All equipment, the environment and resources are available in readiness for dual</p>

		purpose beds being made available.
<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>There were sufficient numbers of toilets and bathrooms for the number of residents and additional staff and visitors' toilets. Twenty four bedrooms have attached ensuite bathrooms with shower and toilet, and all bedrooms have hand basins. Sixteen bedrooms share bathrooms between two to three rooms. Inspection of all bathrooms and toilets showed these were in good condition, were disability accessible with easy to clean walls and floor surfaces and were installed with detachable shower heads and electric heaters. Approved handrails were in place to assist residents with poor mobility and to promote independence. Hot water temperatures were monitored monthly and evidenced acceptable temperatures determined by the building regulations 1992 to minimise risk of scalding/burning. Review of the records for 2019 and hand testing at tap sites reveals temperatures are at or below 45 degrees Celsius.</p> <p>Partial provisional: In preparedness for the reconfiguration a standing/transfer hoist has been purchased. Bathrooms are capable of having a hoist used in them if needed as observed at audit. Upgrading and renovations planned as ongoing maintenance will include modern bathroom fittings and approved handrails.</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>Each of the bedrooms viewed on the two floors wings were spacious and provided space for staff to move freely within their bedrooms safely with plenty of room to accommodate walking aides and other mobility equipment. All residents' rooms were personalised with furnishings, photos, furniture of their choice and other personal items. There were no bedrooms being shared. All the beds provided were in good condition.</p> <p>Partial provisional: The planned reconfiguration for 39 dual purpose beds is supported by the appropriate sized existing rooms. There are four rooms that are larger in size and are appropriate for a higher level care/acuity hospital resident if required. Only room 461 is not appropriate and will stay a rest home level care bed/room.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	FA	<p>Each of the two floors of the rest home has its own lounge area and dining area and there is one other large communal lounge area. Residents' can have meals of their choice in the retirement home large dining room. There is a large lounge which is used for functions and/or activities on the upper level of the rest home. Furniture is appropriate to the setting and residents' needs. The lounge includes a kitchenette that can be used for functions. Dining rooms and lounges are within easy walking distances to bedrooms. Residents interviewed said they were very happy with the range of spaces available to</p>

<p>accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>them. All furniture is safe and suitable for the resident group.</p> <p>Partial provisional: The reconfiguration and needs of hospital level residents are to be further considered and addressed by management when residents are admitted. The two designated dining rooms are adequate currently but for facilitating access of wheelchairs to tables in these areas may prove difficult at times. The numbers of residents however are not increasing. The large communal lounge is available and accessible for dining if required.</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>There is a dedicated cleaner who has worked at this facility for eleven years. The facility is well maintained and is on visual inspection clean and tidy. The laundry duties constitute part of the caregiver/cleaner's duties. The laundry is designed to maximise efficient and safe work flows and linen handling while minimising any cross contamination. The organisation conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. Where improvements can be made these are implemented. The chemical supplier provides ongoing support and information to staff about safe handling of the products in use and reviews the effectiveness of methods and product use. Current material safety data sheets about each product are located with the chemicals. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>Partial provisional: The current laundry and cleaning services would not be affected by the proposed reconfiguration to have dual purpose beds. The services will be monitored as the number of hospital level residents increases and reviewed accordingly at the time.</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 service is maintaining emergency preparedness and management. The emergency management plan continues to be reviewed and updated to ensure it complies with best known practice and statutory requirements. The emergency resources and equipment are kept by the front entrance to the facility in large locked bins. Emergency processes are known to staff. The bins are fully stocked with good quality and appropriate products and equipment suited for older people rest home and hospital level residents. There was sufficient food, water and personal supplies stored to provide for the maximum number of residents and carers in the event of a power outage and to meet the requirements of the local council. Food stores are inspected and checked off as still fit for consumption regularly by the chef and kitchen staff.</p> <p>The facility has back up emergency lighting in the hallways and a generator would be hired if required. There are back up batteries and two water valves that can be used in an emergency. An uninterrupted power supply (UPS) is provided at this facility. Agreement also exists with other care facilities in the organisation for transfer of residents if the buildings are uninhabitable. The fire evacuation approval</p>

		<p>letter from the New Zealand Fire Service (NZFS) reviewed was dated 12 November 2003. The NZFS attends and observes at least one of the six monthly trial fire evacuations each year. The most recent fire drills occurred on 22 May 2019. Outcomes and learning from these exercises are documented and used to improve protocols.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond in a timely manner.</p> <p>Appropriate security arrangements are in place. A security guard is employed and covers the facility 24 hours a day, seven days a week. Sensor lights are installed outside the home. There is an external button at the main entrance for families and/or staff when visiting in the after-hours. There are security cameras throughout the facility. There had been no security issues reported.</p> <p>Partial provisional: There are no proposed changes to the emergency, fire and security systems in place. The reconfiguration does not have an impact on current arrangements. There is no increase in capacity of residents for this service.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The home is centrally heated with gas heating in all hallways. It is optional for residents to have an electric wall heater installed in their individual rooms. There were also heat pumps installed for warmth and cooling in the summer in the rest home. Maintenance staff confirmed that the heating systems were running smoothly. The heaters in each bathroom were functional. The home had sufficient doors and external opening windows for ventilation. All bedrooms had good sized external opening windows which are designed and installed to be secure. The residents and relatives interviewed confirmed that internal temperatures and ventilation are comfortable during summer and winter months.</p> <p>Partial provisional: No changes are required as all rooms currently have adequate ventilation, light and are maintained at a safe and 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, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has implemented an infection prevention and control (IPC) programme to minimize the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from an external infection control consultant. The infection control programme and manual are reviewed annually.</p> <p>The clinical manager is the designated infection control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the general manager and the board members, and tabled at the quality/risk committee meeting. This committee includes the ICC, the health and safety officer, and representatives</p>

		<p>from the nursing team, food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. Information about hand hygiene is posted on notice boards throughout the facility. There were no infection outbreaks reported since the last audit.</p> <p>Partial provisional: The ICC is well prepared for managing any increased risk of infection with the increased acuity of hospital level residents. Robust systems are in place for managing infection prevention and control at this facility.</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 has appropriate skills, knowledge and qualifications for the role, and has been in this role for eleven months. The ICC has attended to an infection control and prevention training through external providers as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory and the GP as required. The ICC has access to residents' records and diagnostic results to ensure timely treatment of any infections.</p> <p>The ICC and interviewed RNs confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed within the last two years and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
Standard 3.4: Education	FA	Interviews, observation and documentation verified staff have received education in infection

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>prevention and control at orientation and ongoing education sessions. Education is provided by the ICC and external providers. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was an increase in urinary tract infections.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing and advice about remaining in their room if they are unwell.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The ICC reviews all reported infection, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against the previous month and year and this is reported to all staff and the infection control committee. Data is benchmarked externally with the other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers should they be required. Policy states that enablers are the least restrictive and used voluntarily at the residents' request. The facility operates a restraint free environment. The restraint coordinator would provide support and oversight for enabler and restraint management if required and the staff interviewed demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of the audit no residents were using restraints and no residents were using enablers. Restraint would only be used as a last resort when all alternatives have been explored. The restraint approval group meeting reflected this. They last met and reviewed policies and procedures at the beginning of this year. Meeting minutes showed that the staff continue to promote a restraint free environment.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</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 Low	<p>The rosters were made available on the day of the audit and reviewed. There is adequate staff to cover the facility currently. The plan for increasing staff to meet the requirements for hospital level residents was discussed. The village and clinical manager are fully aware that the facility will have to be covered by registered nurses 24 hours a day, seven days a week.</p>	<p>The clinical manager is aware that the facility will have to be adequately covered by registered nurses 24 hours a day seven days a week. Additional care staff will also be required to cover the service.</p>	<p>Ensure that the facility is adequately staffed to meet the increased requirements of residents who are assessed as requiring hospital level care.</p> <p>Prior to</p>

				occupancy days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>All reviewed medication charts had current photos for identification and allergies documented. Medication administered was signed for and medicines are stored safely in locked cupboards and the locked trolley in the treatment room.</p> <p>The GP prescribes medication and completes three monthly medication reviews. 12 medication charts were reviewed and two of these were for residents who are on warfarin. Interviewed RNs reported that the GP prescribes warfarin as a verbal order via the phone and the warfarin is administered as a telephone order. An improvement is required to ensure the GP countersigns for the verbal orders given; this was not indicated in the policy. The process to guide staff required clarification in the warfarin administration policy and this was rectified on the days of the audit upon discussion with the clinical manager. The warfarin management policy was reviewed on the days of the audit and will be implemented.</p>	<p>The process for verbal phone orders is documented, but the GP was not signing the verbal orders within the required timeframes.</p>	<p>Provide evidence that warfarin verbal phone orders are countersigned by the GP in a timely manner as per policy.</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>Aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. A verification audit for food control plan was conducted on 10 June 2019. Recommendations to be considered and addressed were documented and in the process of being implemented. The chef has undertaken safe food handling qualification. Kitchen staff were observed to be practising safe food handling techniques on the days of the audit, such as wearing protective equipment and observing appropriate hand hygiene practices. Interviewed kitchen assistants reported that they have not completed food handling hygiene training and there was no evidence of safe food handling training in the three kitchen staff files reviewed.</p>	<p>There was no evidence in the kitchen staff training records reviewed to verify that appropriate education had been provided.</p>	<p>Provide evidence of training on food safety hygiene for all staff working in the kitchen.</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.