

# Edenvale Trust Board

---

## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Edenvale Trust Board
<b>Premises audited:</b>	Edenvale Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 24 September 2019    End date: 25 September 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	41

# 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

Edenvale Rest Home is owned and governed by a board of trustees. The management of the home is overseen by the general manager (GM). The residence provides care for up to 43 residents. There were 40 residents on the day of the audit. Three levels of care are provided - rest home, secure dementia care and hospital level care.

This surveillance audit was conducted in accordance with the relevant Health and Disability Standards and the contract with the district health board (DHB). The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff, management and a general practitioner. Four family members were interviewed on the day of the audit.

Four areas for improvement were identified during this audit relating to assessments, care planning, food service and medicine management. The organisation has maintained the continuous improvement rating around their quality and risk management programme.

## Consumer rights

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

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

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

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

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

There is a robust process for managing complaints and a register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
---	--	--

Business and quality plans include the scope, direction, goals, values and mission statement of the organisation. Reports monitoring the services

provided to the governing body are regular and effective. An experienced and suitably qualified person manages the facility supported by the clinical leader and the administration manager.

The quality and risk management system include collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly. A framework for internal auditing is used and this has been further developed since the last audit. Improvement plans are developed, and corrective action taken to address service shortfalls.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix are sufficient to provide the care needs of residents at all times.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained using integrated hard copy files.

## 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.
--	--	--

Residents are assessed by the Needs Assessment Service Co-ordination (NASC) prior to entry to the service to establish a level of care. Relevant information is provided to potential resident/family prior to entry into the service and on admission to the service.

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

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

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

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

## Safe and appropriate environment

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

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating. The physical environment promotes safe mobility and aids independence.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Cleaning and laundry services are provided by an external contractor onsite and evaluated for effectiveness. Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Families reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

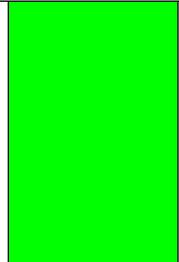
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

The organisation has implemented policies and procedures that support the minimisation of restraint. There are clear and detailed documented guidelines on the use of restraints and enablers. There were no residents using restraint or enablers at the time of the

audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in the management of challenging behaviours.

There is environmental restraint in place to ensure safety of the residents in the dementia unit. There is a keypad exit from the main entrance which enables visitors to come and go as they please.

## 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.
---	---	--

The rest home has an appropriate infection prevention and control management program. The program is resourced to include collection and collation of surveillance data. Benchmarking occurs against previous periods of internal data. Infection prevention activity is evident in the provision of care and potential outbreak identification is well understood. The facility has not had an outbreak since the last audit.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	42	0	2	2	0	0
<b>Criteria</b>	1	89	0	2	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Edenvale Trust Board has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>An admission information pack is provided to consumers at inquiry stage with all the information about the service, service agreement and charges to assist consumers with making informed choices about admission. Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent are defined and documented, as relevant, in the residents' record. Activated EPOA's were sighted in reviewed residents' files where required for example; for residents under dementia level of care. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maintain links with their family and the community by attending a variety of activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families 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>There is a current complaints policy. The policy is included in every admission pack and printed on the back of the complaints forms which are available in the lounge. The GM manages all complaints. Once a complaint is received it is logged in the register which identifies the nature of the complaint and the follow up action taken. Complaints are discussed at staff meetings and at quality and risk meetings. There was evidence that complaints are used to identify areas that can be improved</p> <p>Residents and family (where appropriate) are informed of the outcome of complaints investigations. Residents and relatives interviewed confirmed their knowledge of, and access to, the complaints process.</p> <p>Actions required following a complaint received by the DHB in September 2018 had been implemented and maintained.</p> <p>It was reported by the GM that there have been no complaints or investigations by the Ministry of Health (MoH), Health and Disability Commissioner, District Health Board (DHB) or Accident Compensation Corporation (ACC) since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</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 discussion with the nurses on admission. The Code is displayed in lounge and dining areas</p>

<p>Consumers are informed of their rights.</p>		<p>together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Residents' personal belongings are kept safe and there is a system in place to record personal items brought in for accountability purposes. Records were sighted in reviewed files.</p> <p>Staff were observed to maintain privacy throughout the audit. All rooms have been reconfigured to single use. One couple was sharing a double room, consent forms were sighted in their files.</p> <p>Residents are encouraged to maintain their independence as able for example, participating in provision of own personal cares if desired and with assistance if required. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. Interviewed family and residents reported that there were no suspected or witnessed episodes of abuse and neglect.</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>There are policies in place on Maori health that guide staff to integrate their cultural values and beliefs when required. Interviewed staff demonstrated knowledge and understanding of the principles of the Treaty of Waitangi and how to apply it into day to day practice, for example the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available. There were no residents who identify as Māori on the days of the audit. Interviewed staff reported that they have received training on Maori health and are aware of the cultural needs of Maori. Training records were sighted.</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</p>	<p>FA</p>	<p>Date about individual ethnic, cultural, spiritual, values and beliefs are collected on admission by the RNs through the assessment process. Residents and family interviewed verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences requiring interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p>

their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses and health care assistants (HCAs) have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psycho geriatrician, mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. HCAs and RNs attend to local DHB study days, records were sighted.</p> <p>Other examples of good practice observed during the audit included internal audits completed regularly and corrective actions implemented where required.</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>Residents and family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident 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. Interviewed family confirmed involvement in multidisciplinary meetings where information is shared, and feedback is sought from the residents and/or family.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. There is a policy and procedure in place to guide staff on the process for seeking interpreter services when required. The manager is also available to guide staff</p>

		as required.
<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 rest home is owned and governed by a board of trustees. Contracts are held with the district health board and the Ministry of Health for 21 rest home residents, 12 hospital residents, and 12 dementia residents in a secure dementia unit. One resident funded by a rest home contract is under 65 years old. There were 40 residents in-house on audit day. The facility reconfigured its available capacity from 45 to 43 in September 2018 by using double rooms as single rooms only. This did not require any change to the facility, management or staffing.</p> <p>The GM attends board meetings and writes the annual business plan which is signed off by the board at the beginning of each calendar year. The 2019 business plan was sighted. This sets out the strategy for the organisation. The board has a trust deed which is underpinned by Christian values. The organisation has a philosophy documented in the purpose and objective statement updated in June 2019. The GM provides a progress report on the annual plan at each board meeting. This was confirmed in the board report sampled.</p> <p>The GM is responsible for the day to day running of the home and has been in the role for 18 years, and in management for more than 20 years. The GM has a current contract with the board and a detailed job description. The clinical leader is a registered nurse and supports the GM. The GM is also supported by the administration manager. There is a delegation of authority that defines these roles. The GM keeps skills current through membership of appropriate organisations and attendance at relevant courses.</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>	FA	<p>When the GM is absent, the clinical leader and the administration manager carry out all the required duties under delegated authority with the support of the board chairperson. The clinical leader is an experienced registered nurse who is able to take responsibility for any clinical issues that may arise. The board chairperson provides support as required. There is a formal handover from the GM. Staff reported the current arrangements work well. The service management reflects a resident and family centred approach as indicated in the values of the organisation.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	FA	<p>The organisation has an established quality and risk system that is embedded into practice. Quality data is collected across all levels of the organisation. Committee structure and reporting procedures are set out in documented policies. Quality related information is reported to the quality and risk meeting. (QRM).</p>

<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>QRM meetings are held monthly, monitoring, collation and evaluation of quality and risk data is comprehensive. Quality and risk data, including trends in data and benchmarked results are discussed in the meetings and were evident in meeting minutes sampled. There is evidence of staff involvement in quality and risk management processes.</p> <p>An annual internal audit schedule was sighted. Additional spot audits are also implemented. There is evidence of internal audits occurring as per the audit schedule. Corrective actions are established, implemented and are signed off when completed. The continuous improvement issued at the last audit (refer criterion 1.2.3.7) remains.</p> <p>Residents are asked to complete an annual satisfaction survey and asked monthly at their meetings if there are areas where improvements can be made.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are reviewed every two years (or sooner if requirements change) and new policies, or changes to policy, are communicated to staff. Obsolete documents are removed from circulation. All documents are issued in hard copy. A secure archive storage system is in place.</p> <p>There is an active risk management system. Risks are identified and monitored. Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are implemented. Hazard identification forms and a hazard register are in place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Adverse event reporting is understood and is reflected in policy. The GM confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. An unexplained injury has been reported to the District Health Board and is currently being investigated. It was reported that there have been no other adverse events, incidents or accidents which require reporting to external bodies since the previous audit.</p> <p>There is a comprehensive accident and incident process and a register is maintained. Each accident and incident are reported, and information is used to improve service. Incident reports were sampled and confirmed that family were contacted, investigation was undertaken, and that reporting to staff and quality meetings occurs. Appropriate changes and improvements were made when identified.</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>Policies and procedures identify human resource management that reflect good employment practice and meet the requirements of legislation.</p> <p>Staff files sampled contained job descriptions, employment contracts, qualifications and competencies relevant to the role. Employees who were not from New Zealand had these checks undertaken prior to employment. Professional qualifications are validated, including those visiting of associated professionals, and current practising certificates for the registered nurses were sighted.</p> <p>All staff receive an orientation to the organisation and to their role. There was an electronic education data base, and this showed that all staff had either completed, or were working their way through, the six orientation modules. Staff also undertake training that has been identified as required. Topics for the six modules included the essential components of service delivery and the organisations on-going education requirements under their contract with the district health board. Records of staff education are maintained. All care staff either have dementia qualifications or are enrolled in dementia care units. The clinical leader is an InterRai Assessor and two other registered nurses are InterRAI trained.</p> <p>Formal performance appraisals are undertaken every two years. Ongoing staff performance is monitored by the GM and clinical leader continually between the formal appraisals through a combination of several activities. For example, the internal audits, ongoing observations and attendance at regular staff meetings.</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>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7).The recently appointed clinical leader is responsible for the oversight of clinical services and there is always a registered nurse and at least two nurse aids on site. The clinical leader provides on-call back up. Rosters sampled confirmed that there is a sufficient number of staff with the required skills and knowledge to ensure that all residents' needs were met over the 24-hour period. In the event of an unplanned staff absence, the roster can be filled by another staff member or an agency staff member. The GM has a sound relationship with an agency and has agency nurses who know the home and residents to call on if required. There is also sufficient flexibility that if additional staff are needed due to increased workload this can readily occur.</p> <p>The quality initiative identified at the last audit regarding case management continues. All registered nurses are required to complete the InterRAI requirements for the residents they case manage.</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>Resident records are electronic and integrated. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. 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. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>There are two desk computers and two laptops for staff use to ensure they have ready access for data entry and reviewing information. Care plans are electronic, and the program raises an alert for overdue entries. Archived records are held securely on site and are readily retrievable.</p> <p>No personal or private resident information was on public display during the audit.</p> <p>There are two desk computers and two laptops for staff use to ensure they have ready access for data entry and reviewing information.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The manager is responsible for managing the inquiries and follow up of inquiries when required. A record is kept of all inquiries, records were sighted.</p> <p>The clinical leader and the RNs are responsible for completing the admissions.</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 data, 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>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner by the nursing staff and the GP, with an escort provided as appropriate. The service uses a service specific transfer form to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a resident who was recently transferred to the local acute care facility showed that the family was informed and a follow</p>

		up with the acute service was completed by the clinical leader.
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the days of audit. 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 for all staff who administer medicines were sighted.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge were within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines. Three-monthly GP medication reviews were consistently recorded on the medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. There is a self-medication administration policy in place to ensure this is managed in a safe manner if required.</p> <p>Medication audits are completed by the clinical leader. An improvement is required to ensure that administered pro re nata (PRN) medicines are consistently evaluated for effectiveness.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>The food service is provided on site by an external contractor and is in line with recognised nutritional guidelines for older people. The menu follows summer, autumn, winter and spring patterns and has been reviewed and certified as adequate by a qualified dietitian within the last two years.</p> <p>There is a current food control plan and registration issued by ministry of primary industries. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the</p>

		<p>plan. The unit manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is completed for each resident on admission to the facility and a dietary profile developed. A food service request form is sent to the kitchen staff with personal food preferences, any special diets and modified texture requirements, and these are accommodated in the daily meal plan. Any food requirements changes are made known to the kitchen staff as required. Residents in the secure dementia unit always have access to food and fluids to meet their nutritional needs. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by residents 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>A food verification audit was completed by an external provider on 24 September 2019 and the verification outcome was acceptable. Recommendations from the verification audit were to ensure that fan grills and oven filters are cleaned regularly. Photographic evidence provided post audit showing that the fans have now been cleaned and no further action is required. The corrective action is now closed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The manager reported that phone referrals are also received.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>Residents have their level of care identified through a needs assessment by the Needs Assessment and Service Coordination (NASC) agency before admission. The resident and/family bring a completed resident profile on admission to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. Residents' files reviewed had completed interRAI assessments although they were not consistently completed every six months as required. Residents and families confirmed their involvement in the assessment process. An improvement is required to ensure that interRAI assessments are completed six monthly as required.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Assessment findings in consultation with the resident and/or family/whanau, inform the care plan and assist in identifying the required support for the residents to meet their goals and desired outcomes. Care plans are reviewed six-monthly by the registered nurses as triggered by the electronic software. Infection reports were completed for acute infections and signed off when the condition resolved.</p> <p>Residents' files reviewed evidenced service integration and promoted continuity of service delivery with progress notes, activities note, 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 at shift handovers. Interviewed residents and families reported participation in the development of care plans.</p> <p>An improvement is required to ensure all needs identified by the regular assessments, daily monitoring and interRAI assessments are reflected in 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>Residents and family interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The interviewed GP verified that medical input is sought in a timely manner, that medical orders are followed, and care is implemented promptly. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by an activities coordinator who is undergoing diversional therapy training through Career Force. A visitor assists informally.</p> <p>A social assessment and history are completed on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are completed by the activities coordinator and are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated six-monthly as part of activities care plan review. Daily attendance records are maintained, electronic records were sighted.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and family are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme satisfactory.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the</p>

		<p>people living with dementia. 24-hour activities plans are developed for all residents in the dementia unit. Activities are offered at times when residents are most physically active and/or restless. This includes sing a long music, painting, ball games, simple quiz, tactile and sensory activities, reminiscing and external entertainment.</p> <p>The under 65 residents is comfortable with joining the current activities planned for the rest home and hospital level residents and participates in other individual activities of choice.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Evaluation of progress as clinically indicated was noted for acute infections and wounds. Unresolved problems are added to long term care plans. Residents and families interviewed confirmed involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. There are two GPs contracted by the service and they are on call if required and cover for each other when one is on leave. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to mental health team, wound specialists and ophthalmologist. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. Emergency referral documents were sighted in the reviewed documents.</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>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated maintenance person who ensures minimum quantities of hazardous substances are held onsite. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals were stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were</p>

		<p>observed using this.</p> <p>A hazardous substances list is maintained. Gas bottles are securely stored and checked annually.</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>	FA	<p>A current building warrant of fitness (expiry date 30 September 2019) was publicly displayed.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities were fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is undertaken annually as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The electrician had appropriate current qualifications.</p> <p>Efforts were made to ensure the environment was hazard free, that residents were safe, and independence was promoted. Secure external areas were safely maintained and were appropriate to the resident group and setting. The walking paths were designed to encourage purposeful walking around the garden. A safe, sheltered external area was provided for smokers.</p> <p>Staff, family members/EPOA confirmed they knew the processes they should follow if any repairs or maintenance was required, that any requests are appropriately actioned and that they were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Twenty-six rooms have en suite bathrooms. There are adequate numbers of shared accessible bathroom and toilet facilities throughout the facility for general resident use. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</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</p>	FA	<p>There are 12 dual purpose bedrooms in the rest home area, 15 hospital bedrooms plus 14 bedrooms in the secure care unit. Four rooms in the rest home are double sized but only used as such for married couples who request shared accommodation. Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Rooms are personalised with furnishings, photos and other personal items displayed. Staff and family reported</p>

and setting.		the adequacy of bedrooms.
<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>Communal areas are available for residents to engage in social activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access small sitting areas for privacy, if required. A variety of furniture is provided appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry and cleaning services and trained staff are provided on site by external professional contractors. MSDS and local laundry and cleaning policies were provided. There is a dedicated laundry with commercial appliances and a clean linen room. There are outside lines for drying and airing. Laundry staff are provided by the contractor and demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Family interviewed reported the laundry is managed well and the residents' clothes are returned in a timely manner.</p> <p>Cleaning staff have received appropriate training, were aware of infection control and spill clean-up processes. There is an adequate cleaning room. Cleaning equipment is provided and maintained by the contractor. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored by the contractor and audited by the facility GM. The facility was clean and fresh on audit day. Staff and residents interviewed reported that general cleanliness was consistently maintained.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Emergency planning considers the unique needs of people with dementia. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in 1998 and a small adjustment approved in 2017. The facility has wired smoke alarms, sprinklers, fire hoses and extinguishers, all with current service checks. A trial evacuation takes place six-monthly, the most recent being in September this year (2019). The orientation programme includes response to medical emergencies, fire and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p>

		<p>Adequate supplies for use in the event of a civil defence emergency, including food (7 days), water (500 litre water storage tank), blankets, mobile phones and a gas BBQ were sighted. Emergency lighting is regularly tested and will function on batteries for 7-8 hours.</p> <p>Call bells and sensor mats alert staff to residents requiring assistance. Call system audits are completed on a regular basis and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at 5.00pm daily. There are keypads on all external doors and the entrance to the dementia unit that automatically release if the fire alarms are activated. There is CCTV throughout the facility. Staff do regular security checks at night and reported that they feel safe in the facility.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated to maintain a comfortable environment. Rooms have natural light, opening external windows and communal areas have doors that open onto secure outside garden areas. Heating is provided by individually controlled electric wall panels in resident rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from external specialists. The infection control programme is reviewed annually through an annual report with trend analysis and has goals for the upcoming year.</p> <p>The CL is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results are reported monthly to the monthly quality and risk meeting.</p> <p>The infection control manual provides guidance for staff about how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents.</p>

		<p>There are family meetings that cover aspects of infection control and if they are unwell, it is recommended that they do not visit the service. During higher risk times of community infections and winter months notices are placed at the door to remind people not to visit if they are unwell. There is sanitising hand gel throughout the 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 infection prevention and control coordinator have appropriate skills, knowledge and qualifications for the role. The coordinator has attended education related to infection prevention and control.</p> <p>Additional support and information are accessed from the infection control team at the DHB, the gerontology nurse specialist, the GP and other organisation infection control coordinators. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential 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 reflect the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by the organisation with advice from external specialists. Policies include guidelines for managing outbreaks. Guidelines and policies are reviewed at least biennially and include 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 prevention and control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the infection prevention and control coordinator (RN) and external specialists. Infection control is part of the mandatory training program completed by all staff.</p> <p>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.</p>

		Residents and families receive information and individual education on admission relating to hand washing, soiled linen, disposal of rubbish and continence pads, and remaining in their room if unwell. A resident orientation checklist is completed. Further education is provided if specific incidents occur. The family meetings are used to remind families and visitors regarding standard precautions.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	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. The infection control coordinator reviews all reported infections, and these are documented on a surveillance list. New infections and any required management plan are discussed at handover, to ensure early intervention occurs, with short term care plans developed.  Monthly surveillance data is entered in the electronic data base, collated and analysed to identify any trends, possible causative factors and required actions. Reports identify infection types and infection rates, use of and response to antibiotics. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Where there has been an increase in infections, corrective actions are implemented. There has not been any recorded outbreak of infections in the data sampled since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the clinical leader who demonstrated a sound understanding of the organisation's policies, procedures and practice and staff roles and responsibilities.  On the day of audit, no residents were using restraints or enablers. The restraint policy states that restraint is used as a last resort when all alternatives have been explored. It also states that the use of enablers shall be voluntary, and the least restrictive option will be used to promote and maintain residents' independence and safety. This was evident on review of the restraint approval group meeting minutes and from interviews with staff. Interviewed staff were aware of the difference between a restraint and an enabler. There is a restraint approval group in place.  Restraint competencies were completed for all staff and challenging behaviour and de-escalation techniques are discussed as part of the competency checks.
Standard 2.2.1: Restraint approval	FA	

<p>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>		
--	--	--

## 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)
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	All reviewed medication charts had current residents’ photos for identification. Allergies and sensitivities were documented together with special instructions where required. Medication reconciliation is completed by the RNs and documentation was evidenced on the reviewed files. There were antibiotics in stock and records of the stock on site were kept; antibiotic usage monitoring was conducted. Monthly stock take checks were completed by the RNs. Reviewed electronic medication signing charts evidenced that administered medicines were consistently signed for. However, an improvement is required to ensure evaluation of administered PRN medicines is documented consistently.	Outcomes for PRN medicines administered were not consistently documented.	Provide evidence that administered PRN medicines are evaluated consistently for effectiveness.  180 days
Criterion 1.3.13.5 All aspects of food procurement,	PA Low	The unit manager is responsible for the food procurement and there is a process in place to manage this. On the days of the audit, kitchen staff were observed using appropriate infection control techniques e.g. wearing of hair nets and use of gloves where required. The food preparation area	Verification audit completed for the food services identified that	Provide evidence that the commercial cleaning is completed for the identified areas.

production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		was clean. Food was served from baine marries. Residents were served attractive meals in amounts desired by residents. Residents were given a choice of an alternative meal when requested. The kitchen area was clean, but an improvement is required to ensure that the fan grills inside the cool room and oven filters are cleaned regularly.	dust had built up on the fan grills inside the cool room and the oven filters.	Photographic evidence provided post audit showed that the fans and oven grills have now been cleaned and the corrective action is now closed.  180 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	The RNs utilise the standardised electronic assessment tools to gather information regarding the resident, in consultation with the resident and their relatives where appropriate. Assessments are completed six-monthly, and the information is automatically populated into the care plans. However, some information is not populated as required (Refer 1.3.5.2). There are three interRAI trained RNs including the clinical leader. InterRAI assessments are not consistently being completed six-monthly.	InterRAI assessments were not completed in a timely manner.	Provide evidence that interRAI assessments are completed six-monthly.  90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Care plans are developed in consultation with the resident/whanau. Only two out of seven care plans reviewed reflected all the support needs of the resident, and the outcomes of the integrated assessment process and other relevant clinical information. Information used from assessments, GP medical notes and discharge summaries is used to inform the required support/interventions to meet the residents' needs. Five of seven care plans did not reflect all residents' required interventions and needs/supports. Care plan reviews are not completed following interRAI assessments, as a result, some interRAI triggered needs are not addressed in the care plans.	Five of seven care plans reviewed did not have all the support and/or interventions required to achieve the desired goals and outcomes as identified by the ongoing assessment	Ensure that all needs identified by regular assessments, daily monitoring and interRAI assessments are reflected in care plans  90 days

			process.	
--	--	--	----------	--

## 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>The organisation continues to identify quality issues through its comprehensive quality systems and the review of qualitative and quantitative data. Improvements continue to be made including improved outcomes for residents.</p> <p>An example of an outcome from the continued analysis of the quality data gathered is the addition of spot audits to the internal audit schedule last year. These internal audits have been maintained in specific areas such as the kitchen and laundry and the better service flow and time resource initially achieved has been maintained. This was confirmed in records of audits and interviews with staff.</p> <p>A data base has been installed that enables monitoring of compliance with specified time frames in various areas. For example, staff training requirements; The data base provides an alert when a competency is due for renewal and sends a reminder to the staff member. A further alert is raised if the time frame is not met prompting follow up by the clinical leader. Reports are drawn from the data base to inform reports to the QRM team and to the board. Staff interviews and training records indicate that all requirements are kept up to date.</p> <p>A data base has also been developed to monitor parameters for residents' vital signs and weight. Data is entered daily by care staff. An alert is raised when negative trends occur or a</p>	<p>Continuation of the analysis of the results of internal audits has maintained the better service flow and time resource initially achieved. Improved monitoring of staff training, and resident health status has resulted in better management of resident care with more timely response to changes before they become problems.</p>

		recording falls outside of defined parameters and triggers a re-assessment by the registered nurse. This has resulted in better management of resident care with a real time response to changes before they become problems.	
--	--	---	--

End of the report.