

Victoria Property Holdings Limited - Resthaven

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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: Victoria Property Holdings Limited

Premises audited: Resthaven

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 18 March 2020 End date: 19 March 2020

Proposed changes to current services (if any): The provisional audit was completed to assess the suitability and preparedness of the prospective new owner/director. The intended date of purchase will be as soon as approval is received from HealthCERT. Handover of the facility is intended to be 26 May 2020.

Total beds occupied across all premises included in the audit on the first day of the audit: 37



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Resthaven Lifecare is part of the Heritage Lifecare Ltd group. The service provides rest home and dementia level of care for up to 49 residents. On the day of the audit there were 37 residents.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owner. The provisional audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, general practitioner, staff, manager and prospective new owner/director and area manager.

The care home manager is a registered nurse experienced in aged care management. She is supported by an RN and stable workforce. Residents and family interviewed were complimentary of the service they receive.

The prospective owner operates and owns two other local aged care facilities at rest home, hospital and dementia level of care. The area manager is a registered nurse and an experienced manager in aged care. A transition plan has been developed to ensure a smooth transition for staff under the new ownership. The organisational quality risk system, electronic resident care management system and aged care policies currently used by the prospective owner will be implemented at Resthaven (to be known as Victoria Care following purchase). Existing staff will be interviewed and offered positions under the new ownership. Additional positions will be advertised.

The following shortfalls were identified at this provisional audit around adverse events, training, information on service levels, care plans, activities, aspects of medication management, hot water monitoring, and carpet cleaning.

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 receive services in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up to date when changes occur or when an incident occurs.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The service is owned and operated by Heritage Lifecare. A business plan includes the vision, values and philosophy of care.

There is a documented quality and risk management system. There are a range of policies, procedures, and forms in use to guide practice. Data related to improvement of service delivery is collected. An internal audit schedule is in place with audits completed as per schedule.

The human resource management system is documented in policy with recruitment completed as per policy. There is a documented orientation and annual training plan.

There is a documented rationale for determining staff levels and staff mix to provide safe service delivery in the rest home, hospital, and the dementia unit.

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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The registered nurse (RN) is responsible for each stage of service provision. The RN assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are evaluated at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP) and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Medication competent caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Nutritious snacks are available 24 hours. Residents were very satisfied with the meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are sufficient numbers of showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are monitored through the internal auditing system. Laundry is completed off site. There is a civil defence kit and evidence of supplies in the event of an emergency in line with civil defence guidelines. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training around management of challenging behaviour. There were no enablers or restraint in use during the audit.

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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The 1/clinical leader is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection prevention and control education. Surveillance data is collected, collated, and discussed in staff and registered nurse meetings. There have been no outbreaks.

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	37	0	4	4	0	0
Criteria	0	85	0	4	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies and procedures are in place to ensure resident rights are respected by staff. Staff receive education during orientation and ongoing training on consumer rights is included in the staff annual training plan (provided September 2019 and February 2020). Care staff interviewed (four caregivers, one registered nurse, one cook, one maintenance person, one housekeeper and one activities staff member) were able to describe their responsibilities around the Health and Disability Commissioner's Health and Disability Services Consumers' Rights (the Code).</p> <p>The interview with the prospective provider (the prospective owner/director and the prospective area manager) confirmed that they manage two other facilities and were able to describe application of consumer rights.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General written consents are obtained on admission. The admission agreement includes permissions granted (eg, medical information and photographs). All six resident files (three rest home including one resident under long-term stay – chronic health condition and one resident under ACC and three dementia level of care residents including one younger person) contained signed consents.</p> <p>Resuscitation status had been signed appropriately. The general practitioner (GP) assesses the resident's</p>

<p>they need to make informed choices and give informed consent.</p>		<p>competency to sign for a resuscitation decision and where the resident is deemed not competent makes a medically indicated resuscitation decision in discussion with the EPOA (enduring power of attorney). Advance directives were available identifying the resident's or EPOA wishes for end of life care, including hospitalisation. Copies of the EPOA had been activated in the three dementia care files reviewed.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>The two relatives interviewed, confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Information on advocacy services is available at the entrance to the service. Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files include information on resident's family and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There are no set visiting hours and family reported that they are encouraged to visit at any time. Residents confirmed that they are supported and encouraged to access community services independently or as part of the planned activities programme. Residents continue to be as independent as possible with activities in the community.</p> <p>Residents in the rest home are identified as being independent and mobile.</p> <p>The service encourages the community to be a part of the residents' lives in the service with visits from entertainers.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	<p>FA</p>	<p>Policy and procedures are in line with Right 10 of the Code and identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints.</p> <p>Complaints management is explained as part of the admission process with the policy and forms included in</p>

<p>understood, respected, and upheld.</p>		<p>the information pack given to potential residents and family. Complaints forms include contact details for advocacy services. Training on the complaints policy and process is part of the staff orientation programme and ongoing education.</p> <p>There is an up to date complaints register retained in the complaints folder. There were three complaints recorded for 2019. All have been investigated to the satisfaction of the complainant and resolved. One complaint for 2020 remains in progress.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Information on the Code and the Nationwide Health and Disability Advocacy Service is displayed in the facility including pamphlets available for residents and family in the dementia unit and rest home. The service provides information on the Code to families and residents on admission. Residents (six from the rest home), and family (two from the dementia unit) interviewed, stated that they believe their rights were met as per the Code. Information around advocacy services and the Code is discussed with residents and relatives on admission. Residents and relatives interviewed confirmed that the Code and the advocacy services were explained on admission.</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>There are a range of policies and procedures to ensure residents are treated with respect. There is respect for residents' spiritual, cultural and other personal needs as confirmed by residents and family interviewed. Residents are referred to by their preferred name as observed on the day of audit.</p> <p>The service ensures that each resident has the right to privacy and dignity. Discussions of a private nature are held in the resident's room and there are areas in the facility that can be used for private meetings. Staff reported that they knock on bedroom doors prior to entering rooms and ensure doors are shut when care is being completed as observed on the day of audit. Verbal handovers and personal discussions are held in private areas. Residents and families confirmed that physical privacy is respected.</p> <p>Staff receive training annually on abuse and neglect (February 2020) and could describe signs and reporting requirements. Residents personal belongings are not used for communal use.</p> <p>There are quiet, low stimulus areas that provide privacy for residents in the dementia unit.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and</p>	<p>FA</p>	<p>There are policies and procedures covering cultural safety and cultural responsiveness. The documentation is referenced to the Treaty of Waitangi and includes guidelines on partnership, protection, and participation.</p> <p>Staff interviewed confirmed an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training. Staff interviewed</p>

<p>disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>described how they consult with residents and family who identify as Māori and work with them to provide culturally appropriate care. There is one resident that identifies as Maori.</p> <p>Access to Māori support and advocacy services are available through the DHB if required and has links with Māori-based primary services.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan. Staff interviewed confirmed their understanding of cultural safety in relation to care. Residents and family members interviewed confirmed that staff respect their values and beliefs.</p> <p>Care staff interviewed could describe how they communicate by using signs and body language for residents who have difficulty communicating or residents who have English as a second language. Interpreting services are available.</p> <p>The interview with the prospective provider confirmed that they already own two aged care facilities and could describe communication with residents who have dementia and also of different cultures.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in policy and job descriptions. Staff sign a confidentiality clause and house rules on employment.</p> <p>Staff interviewed demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives reported that staff maintain appropriate professional boundaries, including the boundaries of the caregiver role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are policies and procedures to guide practice. These align with the Health and Disability Services Standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by support office. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice with this able to be described by clinical staff.</p> <p>Family members interviewed confirmed they are very happy and satisfied with the care provided to their relatives and expressed a satisfaction with the care delivered.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There are policies covering communication with residents/relatives, and management interviewed, reported that they have an open-door policy. Information is provided in a manner that the resident can understand. Relatives and residents can discuss issues at any time with staff.</p> <p>The incident and accident forms include an area to document if the relatives have been contacted. Thirteen incident forms reviewed identified family were informed where required. Open disclosure is practised and documented when family are contacted. The general practitioner interviewed, reported satisfaction with communication from staff.</p> <p>Resident meetings have commenced (meeting minutes sighted) and are open to families to attend. All aspects of the service are discussed, and residents are encouraged to participate and provide suggestions for improvement.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Resthaven Lifecare is owned and operated by Heritage Lifecare Limited. The service provides rest home and dementia level care for up to 49 residents. On the day of audit there were 17 rest home level residents in the 25-bed rest home and 20 residents in the 24-bed secure dementia unit. There were two residents funded through the younger person disabled contract (one rest home and one dementia care level), one rest home level resident funded through ACC and one rest home level resident funded through the long-term support – chronic conditions contract.</p> <p>The mission statement and philosophy of care are documented. Heritage’s overall vision and values are displayed in a visible location. All staff are made aware of the vision and values during their induction to the service. There is a business plan for 2019 with 2020 in the process of development. There is a documented quality plan in place. Monthly reports to support office include business and quality objectives.</p> <p>The clinical services manager is a registered nurse who has been in management roles at Resthaven for two and a half years. She has maintained relevant professional development hours. She is supported in her role by a newly qualified registered nurse.</p> <p>The prospective owner owns and operates two local aged care facilities (one rest home and the other facility - rest home/hospital and dementia care) in Christchurch. The prospective owner will continue as the general manager, overseeing the three services. He will be supported in this role by the area facility manager (an RN with experience in both management and clinical roles).</p> <p>Service-specific management will be provided by an existing area clinical manager (an experienced registered nurse) who will be on site daily. There will also be a clinical coordinator full time on site. This staff member is already employed and working at one of the sister sites as an extra staff member.</p>

		<p>The prospective owner and area facility manager are experienced managers and currently manage two other facilities. The prospective owner attends the ARC forums and cluster meetings at the district health board. The DHB are aware of their potential purchase.</p> <p>There is a transition plan to ensure a smooth transition during the change of ownership. The intended settlement date is 26 May 2020.</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>During the temporary absence of the care home manager, the new RN and an experienced enrolled nurse will undertake the role with support from Heritage support office. For the prospective owner, the area clinical manager will take the clinical coordinators role in their absence.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a quality and risk management framework that is documented to guide practice. The service implements organisational policies and procedures to support service delivery. All policies have been developed by support office and are reviewed according to schedule. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. A document control system is implemented, and this ensures that documents are approved, up-to-date, and managed to preclude the use of obsolete documents.</p> <p>Service delivery is monitored through review and resolution of complaints; review of incidents and accidents; surveillance of infections; monitoring for any pressure injuries; feedback from residents and family and implementation of an internal audit programme. The internal audit schedule is documented annually with audits completed as per schedule. Corrective action plans have been developed for results less than expected and signed off when completed.</p> <p>There is an implemented schedule of meetings. Meetings included: monthly quality/staff and weekly senior staff meetings which allow for discussion and review of data. Meeting minutes confirmed that all areas of the quality and risk management programme are discussed including infection control and health and safety. Staff reported that they are kept informed of quality improvement and risk management through meetings.</p> <p>A survey was last completed during July 2019. There was positive feedback. An action plan implemented included improvements to the activity teams process.</p>

		<p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented and align with new legislation. There is a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards including any maintenance issues are addressed as soon as they arise, and risks are eliminated, minimised or isolated. Review of incidents, risks, accidents, and clinical issues are discussed through quality/staff meetings as part of the health and safety programme.</p> <p>The prospective owner engages an aged care consultant to provide and review all policies and procedures that will be transferred across to the new facility. The external provider also provides a quality data system to collate, and benchmark all data and this will be implemented as part of the systems change for the new facility.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are reviewed and signed off by the care home manager. Not all identified incidents had been reported and not all had been followed up to ensure resident safety.</p> <p>The 13 incident forms reviewed showed evidence of immediate responses, investigations and remedial actions being documented on the incident form. This includes reporting to family members and informing the general practitioner as needed. Both family and the general practitioner interviewed confirmed that incidents are reported in a timely manner. Neurological observations are documented for a fall with a head injury or an unwitnessed fall.</p> <p>The care home manager could describe the statutory and/or regulatory obligations in relation to essential notification reporting and could describe the process of notification to the correct authority where required. A section 31 had been sent to HealthCERT for the following during 2019; a resident fall resulting in a fractured femur, an unstageable pressure injury, an altercation between two residents (three reports), a medication prescribing error, an interruption to service (a flood caused by builders), a missing resident (two reports), a dementia resident climbing the fence, and an unexpected death.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>PA Moderate</p>	<p>There is an established system in place for human resource management. Six staff records reviewed (one RN, and five caregivers) included an employment agreement and a position description. Reference checks are completed for new staff. Staff have criminal vetting prior to appointment and professional qualifications are validated. All staff receive an orientation with a record of this maintained on staff files reviewed. The orientation programme covers key aspects of the organisation and service delivery including special care requirements for hospital, dementia and rest home levels of care. There is a schedule for staff annual</p>

<p>practice and meet the requirements of legislation.</p>		<p>performance appraisals.</p> <p>The training plan meets the mandatory requirements. Training has not all been completed as planned and not all staff have achieved eight hours attendance at training. Staff complete competencies relevant to their role such as fire safety, infection control, restraint, challenging behaviour and medications.</p> <p>There are 19 caregivers who work in the dementia unit, not all have achieved the dementia unit standards within set timeframes.</p> <p>The care home manager is interRAI trained.</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>The process for determining provider levels and skill mix is defined in policy and considers the layout of the facility and levels of care provided, but staffing has not been adjusted to match levels of care need. Rosters and staff interviewed, and observation on the days of audit, confirmed there were not sufficient numbers of staff in the dementia unit to meet minimum requirements as specified in the contract with the district health board. Rosters reviewed confirmed that staff are replaced when on leave.</p> <p>The care home manager is on duty Monday to Friday and provides on call. Staff stated that on call staff respond promptly. A newly qualified registered nurse is on duty on varying days of the week.</p> <p>The secure dementia unit had 20 residents on the day of audit; an enrolled nurse rostered is five days a week plus two caregivers for each of the AM, PM and night shifts.</p> <p>The rest home had 17 residents on the day of audit. Two caregivers are rostered for each of the AM and PM shift and one for the night shift.</p> <p>The prospective owner has developed a roster for the service; this includes;</p> <p>An RN/unit coordinator seven days a week for the service.</p> <p>Two caregivers for each of the AM and PM shift for the rest home and one on nights.</p> <p>Three caregivers for each of the AM and PM shifts in the dementia unit and one on nights.</p> <p>A diversional therapist and an activities coordinator are also planned.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is</p>	<p>FA</p>	<p>Resident records are integrated. Resident records in use are maintained confidentially with these locked in a secure area when not in use. Progress records are documented by the care staff in the paper-based record. The date, time, signatures, and designation of those entering into the records is legible.</p>

uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		
<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>	PA Low	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack they offer residents on admission however there is no specific information on dementia level of care. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Six admission agreements sighted were signed and dated.
<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	Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service.
<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>There are comprehensive policies and procedures in place for all aspects of medication management. Registered nurses and senior caregiver's complete medication competency and attend medication education. All medications are stored safely. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications checked in were recorded in the electronic medication system. The room air temperature is monitored and below 25 degrees Celsius. The medication fridge is monitored daily; however, there were no corrective actions for temperatures outside of the acceptable range. Eye drops had been dated on opening. There were no residents self-medicating.</p> <p>Twelve medication charts were reviewed on the medication electronic system. All medication charts had photograph identification, but not all charts had an allergy status identified. Medications are reviewed at least three-monthly by the GP. The effectiveness of 'as required' medications was documented in the electronic medication system.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	The service employs a kitchen manager/qualified chef who is supported by cooks and morning and afternoon kitchenhands. The kitchen manager oversees the procurement of the food and management of

<p>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>the kitchen. All food services staff have completed food safety and hygiene training. There is a well-equipped kitchen and all meals are cooked on site. The four-week rotating menu has been reviewed by a dietitian in April 2019. Food is served from a bain marie to the rest home residents in the adjacent dining room. Meals for the dementia unit are plated with insulated lids and bottoms and delivered by trolley to the unit dining room. The service uses pure foods for pureed textured meals. A vegetarian option and gluten free meals is provided. The kitchen manager receives dietary profiles for all residents. Dislikes are accommodated. There are nutritious snacks and foods available 24-hours including smoothies, high protein drinks, sandwiches, fresh fruit, home baking and extra desserts.</p> <p>The food control plan expires 23 November 2020. All perishable foods are dated. Decanted dry goods are either in original packaging or have refill and expiry dates on containers. Fridges, chiller and freezer temperatures are taken and recorded twice daily. Inward goods, end cooked and serving temperatures are taken and recorded. Rinse and wash dishwasher temperatures are taken and recorded daily. The chemical provider services the dishwasher monthly for the effectiveness of chemicals used. All chemicals are stored safely. There is a daily, weekly and monthly cleaning schedule which has been maintained. Contractors complete high wall and ceiling cleaning duties.</p> <p>Feedback on meals is received directly, through meeting minutes and surveys. All residents and the family members interviewed were satisfied with the meals offered.</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>The service records the reason for declining service entry to potential residents should this occur and communicates this to the potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency and/or given suggestions of facilities offering appropriate services.</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>Files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Paper-based risk assessments had been completed on admission as relevant, such as falls, pressure injury, pain, oral and nutritional assessment and continence. Challenging behaviour assessments had been completed for dementia care residents and any rest home residents with challenging behaviours. InterRAI assessments had been completed for all long-term residents' files reviewed (including the LTS-CHC resident, ACC resident and younger person). Goals were identified through the assessment process and linked to care plan interventions. InterRAI assessments</p>

		are completed for significant changes in health status. One resident in the dementia unit (younger person) has been re-assessed and declined higher level of care until the effect of medication review is known.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. Care plans are resident-centred, however not all interventions were documented to meet support needs and provide detail to guide care. Care plans reflected the outcomes of interRAI assessments. Dementia care residents had behaviour management plans in place with appropriate interventions to de-escalate behaviours. Short-term care plans are in use for changes in health status and short-term needs as sighted for infections and wounds. Rest home residents and the relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of allied health professionals.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the registered nurse initiates a nurse specialist or GP consultation. The RN interviewed stated that they notify family members about any changes in their relative's health status. Resident files have a family/whānau contact page with documented discussions with family/EPOA for changes to care, accident/incidents, GP visits, medication changes, behaviours of concern and multidisciplinary reviews. Family members interviewed stated their expectations for their relatives were being met. Care staff interviewed, stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies. There were two wounds being treated and monitored for rest home residents. There were eight wounds (including one surgical wound and one stage two pressure injury on the spine) for dementia care residents. There were wound assessment, wound management and evaluation forms in place and wound monitoring occurred as planned. Wound measurements and photographs demonstrate the healing process. Reported bruising is monitored as part of the wound management procedures. Monitoring forms are in use as applicable such as weight, vital signs, neurological observations, re-positioning charts and food and fluid intake. There was evidence of behaviour charts being used for residents that exhibit challenging behaviours.
Standard 1.3.7: Planned Activities Where specified as part of	PA Low	There is one activity coordinator who has been in the role 18 months and previously worked in housekeeping for five years at the facility. She completed an orientation day at another Heritage rest home/hospital facility with a diversional therapist. The activity coordinator has not yet commenced dementia unit standards (link

<p>the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>1.2.7.5). The activity coordinator works from 9 am to 3 pm Monday to Friday. There is one programme across the two levels of care with integrated activities for rest home and dementia care residents such as bowls, church services and entertainment, however there is no programme of activities for dementia level residents which is appropriate to their level of care. There are secure folding doors between the rest home lounge and the dementia care lounge which can be opened up for entertainment. Activities offered include (but not limited to); exercises, games, newspaper reading, quizzes, music, arts and crafts and walks outside. One-on-one contact is made with residents with individualised activities such as pampering, nail care, reminiscing and discussions. The maintenance person brings in their pet dog daily and there is a home cat. There are regular shop trolley and library trolley rounds. Special events and festive occasions are celebrated.</p> <p>A van driver with a first aid certificate drives for the twice weekly van outings to places of interest and picnics. There is a coffee group that walk to the nearby café. The men's group (rest home and dementia care) meet monthly for men's activities. There are individualised activities documented for the younger person, ACC resident and residents under the LTS-CHC contract. They are encouraged to maintain their former links and attend community groups. The men join in the men's group and two residents attend a local community group for lunch and entertainment.</p> <p>A social profile and list of interests is obtained on admission. The long-term care plan includes a section on socialising and activities. The long-term care plan is evaluated six monthly, however there is no documented evidence the activity coordinator is involved in the MDT review. A 24-hour clock form was included in the dementia care residents' files reviewed; however, these were incomplete and did not include activities.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Five of six long-term care plans (one dementia care resident had not been at the service six months) had been evaluated against the resident goals as met or unmet, by the registered nurse or facility/clinical services manager/RN six monthly. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary team review involves the RN, GP if available and resident/family if they wish to attend (link 1.3.7.1). There are three-monthly reviews by the GP for all residents. The family members interviewed confirmed that they are involved in the MDT evaluation of the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of a resident who had been re-assessed for a change in level of care. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>

<p>access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</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>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturers' labels. There is a main chemical storage shed which is locked when not in use. Safety datasheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. Gloves, aprons, and goggles are available for staff. There is a sluice room in each unit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building holds a current warrant of fitness which expires 1 July 2020. There is a maintenance person on site who works 20 hours per week. Requests for maintenance and repairs are written into a logbook which is signed off when repairs are complete. There are essential contractors available 24-hours. The maintenance person completes a monthly facility check which includes monitoring hot water temperatures in resident toilets/showers. There were no corrective actions documented for temperatures above 45 degrees Celsius. Testing and tagging of electrical equipment and calibration of clinical equipment has been completed.</p> <p>All corridors are wide enough to promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well-maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>There is a large secure outdoor garden and walking pathway in the dementia care unit. There are four entry/exits areas to the outdoors. Seating and shade is provided and there is natural shade provided by trees in the grounds. There are raised gardens.</p> <p>Caregivers stated they had sufficient equipment to safely deliver cares as outlined in the resident care plans. There is a hoist available for use for falls.</p> <p>The prospective new owner/director confirmed on interview there will be renovations including refurbishment</p>

		of the interior and new furnishings. Exterior renovations include upgrading fences.
<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	Residents in the rest home share communal toilet/shower rooms. There are two rooms in the dementia unit with ensuites. There are sufficient communal toilets and showers in both units. Fixtures, fittings and flooring are appropriate for this setting. There is space in toilet and shower areas to accommodate shower chairs if appropriate. There are privacy signs on all shower/toilet doors.
<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	All rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility aids. Staff interviewed, reported that there is adequate space to provide care to residents. Resident rooms were personalised as viewed on the day of audit.
<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>In the rest home unit, there is a large open plan lounge and dining room. There are separate seating areas with doors that open out onto the gardens with seating and shade. The rest home has a small kitchenette where tea/coffee making facilities are available for residents and their families.</p> <p>The dementia unit has an open plan lounge/dining room and a separate lounge with conservatory, with doors that open out onto the walking pathway. There is a sensory room for quieter activities.</p>
Standard 1.4.6: Cleaning	PA Low	All laundry is done off site. The laundry is divided into a 'dirty' and 'clean' area. Dirty laundry is collected

<p>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>from the dirty side and delivered into the clean side where it is sorted and distributed to the unit's linen cupboards. There is a domestic washing machine for delicates. The cleaner's trolley was attended at all times or locked away when not in use in the cleaner's room (one in each unit). A cleaning schedule is maintained including the regular waxing of carpets, however there remained a urine odour on both days of the audit. There is personal protective equipment readily available. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. There are laundry and cleaning procedures available. Cleaning and laundry services are monitored through the internal auditing system and eternally by the chemical provider.</p> <p>Provisional: The prospective owner/director aims to re-open the laundry and complete laundry on site.</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>There is an approved evacuation scheme. Evacuation drills occur at least six monthly, with the results of these documented. There is a staff member on duty 24/7 with a current first aid certificate.</p> <p>In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare batteries for lights, a gas barbecue, linen, continence products, torches and batteries, water and blankets. There is a generator available for hire if required. Food dry stock and frozen food are available to support residents for at least three days. On the two days of audit the main water store tank was empty due to a leak. The maintenance person was in the process of mending the leak. The water tank was not able to be refilled by the end of audit. Advised that current water stored on site was within the guidelines for Canterbury of 333 litres without the water tank being out of action.</p> <p>A modern call bell system was in all resident rooms, communal areas and toilet/shower facilities.</p> <p>The entrance to the dementia unit are secured with keypad entry. A perimeter fence around the dementia unit with locked gates ensures residents are kept safe. Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately.</p> <p>External doors are locked in the evening. The RNs have a mobile phone, there is external lighting.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an</p>	FA	<p>All bedrooms and communal areas have natural light and ventilation. All heating is radiator heaters that are thermostat adjustable. There are opening windows in resident bedrooms and doors that open to the outdoors in communal areas. There is a designated smoking shelter in the grounds where residents may smoke. All other areas are smoke free.</p>

<p>environment that is 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>	<p>FA</p>	<p>Resthaven has an infection control programme that is reviewed annually at support office and results used to improve services through training. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The care home manager is the designated infection control coordinator. Infection control is discussed at the staff meetings. There are sufficient supplies of personal protective equipment and outbreak management resources including a pandemic plan.</p> <p>Visitors are asked not to visit if unwell. Residents are offered the influenza vaccine. There were hand sanitisers placed 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>	<p>FA</p>	<p>There are adequate resources in place to implement the infection control programme. The infection control coordinator (clinical leader) had completed an infection control course 2018. The infection control coordinator reported that they can seek advice from the DHB infection control nurse, gerontology nurse specialist and district nurses when needed. The GP is readily available for advice and monitors the use of antibiotics. Hand washing facilities are available throughout the facility and hand sanitiser was freely available. There were also adequate supplies of gloves, continence products and wound care supplies.</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</p>	<p>FA</p>	<p>Infection control policies and procedures have been developed by the Heritage support office. Staff were familiar with the policies and could describe best practice. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training, and education of staff. The policies have been reviewed annually by the infection control coordinator.</p>

and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection prevention and control is included in the orientation programme for new staff. Infection control education has been held annually. Staff receive topical updates on infection control matters at handovers and staff meetings. Staff also receive one-on-one training as required. Staff complete infection control competencies including hand hygiene.</p> <p>Information is provided to residents and visitors that is appropriate to their needs. Residents are educated in the use of sanitisers and the importance of hand washing.</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>	FA	<p>The infection control coordinator is responsible for the surveillance programme of infections. Standard definitions, types of infections are documented to guide staff. Information is collated monthly and clearly documented in the infection log maintained by the infection control coordinator. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Infections are investigated, and appropriate plans of action were sighted in meeting minutes. The surveillance results, trends and analysis are discussed at the staff and registered nurse meetings. Monthly data is benchmarked with reports and graphs generated for the service. Infection control data is discussed with management and staff. Corrective actions are developed for any areas of concern. Audits have been conducted and included hand hygiene and infection control practices.</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>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Resthaven has policies and procedures around restraint minimisation and safe practice. There were no residents using restraints and no residents with enablers at the time of the audit. Staff receive training on restraint minimisation and safe practice and complete competency questionnaires.</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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA</p> <p>Moderate</p>	<p>There is a well-documented process for incidents and accidents, this includes the completion of an incident report and follow up. Not all identified incidents were documented on the incident system and not all had been documented as fully followed up.</p>	<p>(i). There was one pressure injury identified that had no corresponding incident form.</p> <p>(ii). One incident form identified corrective action for a resident choking incident. These actions (sitting up for meals and supervise meals) were not reflected in the resident care plan.</p>	<p>(i). Ensure that all identified pressure injuries incidents have a corresponding incident form.</p> <p>(ii). Ensure that identified action to improve resident safety/care are documented in the resident's care plan.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to</p>	<p>PA</p> <p>Moderate</p>	<p>There is a documented education schedule in place, but this has not</p>	<p>(i). Not all training has been completed as per schedule including; manual handling, cultural awareness,</p>	<p>(i). Ensure that all training is completed as</p>

<p>identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>always been followed for 2019. There is a plan in place to catch up 2020. The service records all training including individual staff member attendance, not all caregivers had attended eight hours training over the last year. There is an expectation by the service that all staff complete the dementia unit standards and staff are supported to achieve this qualification. However not all staff who work in the dementia unit have completed the dementia unit standards within set timeframes.</p>	<p>sexuality, pain, falls, death and dying, health and safety, and emergency response.</p> <p>(ii). The training records for three caregivers did not evidence eight hours training in the last year.</p> <p>(iii). Two caregivers and an activity person who work in the dementia unit have not completed the dementia unit standards within set timeframes.</p>	<p>per the training schedule.</p> <p>(ii). Ensure that caregivers attend eight hours of training annually.</p> <p>(iii). Ensure that all staff that work in the dementia unit complete the dementia unit standards as set in the ARRC contract.</p> <p>90 days</p>
<p>Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	<p>PA Low</p>	<p>The service has a general information pack on services provided for rest home level of care, however dementia care services is not included in the information pack.</p>	<p>The information pack does not include written information on particular practices in dementia care such as behaviour management and a secure and safe environment as per the DHB contract for dementia care services.</p>	<p>Ensure the information pack includes dementia-specific information.</p> <p>90 days</p>
<p>Criterion 1.3.12.1 A medicines management system is implemented to</p>	<p>PA Moderate</p>	<p>The medication fridge is monitored and temperatures recorded daily, however the temperatures are not always within the acceptable range. The service uses an</p>	<p>(i) The medication fridge temperatures had been recorded above 8 degrees Celsius on several consecutive days during the last few months without any documented evidence of corrective actions; and (ii) two medication charts did not have an allergy status</p>	<p>(i) Ensure medication fridge temperatures are within the acceptable range; and (ii) ensure all medication charts</p>

manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		electronic medication system. All medication charts met the prescribing requirements and are reviewed at least three monthly by the GP. Not all medication charts had an allergy status identified.	identified.	have an allergy status identified. 60 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	The three-rest home resident care plans had documented interventions to meet the resident's needs; however, not all interventions had been documented in the three dementia care plans to meet the health and care needs of the resident.	(I). There was no seizure management plan for the younger person following admission to hospital with a seizure six months ago. The same resident's mobility status had deteriorated and not updated on the care plan. An interRAI re-assessment and referral to the psychiatrist was initiated. A delay in re-assessment and decision has resulted in increased needs for the resident; (ii) a resident (dementia unit) with a healing stage two pressure injury of the spine and assessed at high risk of pressure injury did not have pressure injury prevention strategies documented in the care plan. There was no short-term care plan for weight loss, food/fluid monitoring or update of nutritional profile for the same resident with unintentional weight loss, and (iii) there were no falls prevention strategies documented for a resident (dementia unit) assessed at moderate falls risk.	(i)-(iii) Ensure care plans meet the current medical and care needs of residents. 60 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated	PA Low	There is one activity programme used across the two levels of care and it is not always appropriate for dementia care residents to integrate with the rest home	(i) The integrated activity programme does not include flexible meaningful activities appropriate to dementia level of care, for example household and sensory activities; (ii) there was no documented evidence of the activity coordinator being involved in the MDT	(i) Ensure there is a flexible activity programme for dementia care residents that is

<p>to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>activities. Long-term care plans incorporate a section on socialising and activities which is evaluated six monthly, however there is no evidence the activity coordinator is involved in the MDT review. There are 24-hour clock forms in the files of dementia care residents but these did not include activities.</p>	<p>evaluation of the long-term care plan that included socialising and activities; and (iii) 24-hour activity clock forms were incomplete and did not include individualised meaningful activities.</p>	<p>appropriate to the level of care and cognitive abilities of the residents, (ii) ensure the MDT evaluation of the socialising and activities section of the long-term care plan includes the activity coordinator; and (iii) include individualised and meaningful activities into the 24-hour clock for dementia care residents.</p> <p>90 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>There are monthly facility checks carried out that include the monitoring of hot water temperatures. Records show there were no documented corrective actions for temperatures above 45 degrees Celsius.</p>	<p>Hot water temperatures in communal toilet/shower areas fluctuate between 48-55 degrees Celsius. An electrician has replaced two pumps and tempering valves, however there has been no documented corrective actions for further temperature fluctuations. The hot water temperatures were checked on the day of the audit (at the auditor's request) and these were recorded below 45 degrees Celsius.</p>	<p>Ensure hot water temperatures in resident areas are maintained below 45 degrees Celsius.</p> <p>90 days</p>
<p>Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>PA Low</p>	<p>There was a cleaning schedule in place that included weekly waxing or more often as required. Carpets were waxed in the dementia unit during the audit as scheduled, however a urine odour remained.</p>	<p>A urine odour was noted in the dementia unit on both days of the audit despite a scheduled wax of carpets completed.</p>	<p>Ensure urine odours are eliminated.</p> <p>90 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.