

Springvale Manor Limited - Springvale Manor Rest Home

Introduction

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

The audit has been conducted by 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:	Springvale Manor Limited
Premises audited:	Springvale Manor Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 9 September 2020 End date: 10 September 2020
Proposed changes to current services (if any):	The addition of two further beds in the dementia unit has been verified.
Total beds occupied across all premises included in the audit on the first day of the audit:	27

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

Springvale Manor provides care for up to 27 residents at rest home and secure dementia level of care. On the day of audit there were 27 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, staff, management and general practitioner.

This audit also included verifying two additional rooms in the dementia unit as suitable for dementia level care residents.

The service has a mission that supports a family friendly service.

The service is managed by an experienced manager and a registered nurse. Residents and relatives interviewed spoke positively about the service provided.

There are improvements required around; the quality and risk system, staff training, integrated files, timeliness of care plans, care plan availability and care plan interventions, evaluation of care plans, resident referral, medication management, service maintenance, civil defence stores and infection control.

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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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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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A quality and risk management programme is documented. Data is collected and analysed, and changes are made as a result of trend analysis. Quality improvement plans are developed when service shortfalls are identified. Residents receive appropriate services from suitably qualified staff. An orientation programme is in place for new staff and an annual training plan. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service has assessment processes and resident's needs are assessed prior to entry. There is an information pack available for residents and families/whānau at entry. The RN or EN is responsible for assessments, care plans, interventions and evaluations. Risk assessment tools including interRAI assessments and monitoring forms were available. The general practitioner reviews residents at least three-monthly. Other allied health professionals are involved in the care of residents.

A diversional therapist coordinates and implements an activity programme that meets the abilities and individual recreational needs of all residents. There are integrated group activities such as entertainment and weekly outings into the community.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies.

All meals and baking are prepared and cooked on site by qualified cooks. Resident's individual dietary needs and dislikes were identified and accommodated. Staff have attended food safety and hygiene training. Additional 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.		Some standards applicable to this service partially attained and of low risk.
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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The buildings hold a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. There is a safe outdoor area and walking pathway within the secure unit and garden. Resident bedrooms are personalised. Rest home rooms have an ensuite. There is access to an adequate number of communal toilet/shower facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme. There is at least one staff member on duty 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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The service has appropriate procedures and documents for the safe assessment, planning, evaluation, monitoring and review of restraint and enablers. At the time of the audit there were five dementia care residents with a restraint and no residents using an enabler. Staff complete restraint competencies. Internal audits monitor compliance of policy and procedure.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The service collects antibiotic related infections and reports them to meetings. There have been no outbreaks since the previous 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)
Standards	0	38	0	8	4	0	0
Criteria	0	86	0	12	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation (link to 1.2.7.5). Interviews with staff (three caregivers, one registered nurse (RN) and one diversional therapist, one housekeeper, a laundry person and the cook) confirmed their understanding of the Code. Three rest home residents and three relatives of residents in the dementia unit confirmed that staff respect privacy and support residents in making choices.</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</p>	FA	<p>There are established informed consent policies/procedures and advance directives. General consents were obtained on admission and sighted in six of six resident files reviewed (four dementia care and two rest home residents). Advance directives where available were completed. Resuscitation plans were sighted in all files and signed appropriately for the competent rest home residents. For residents deemed to be incompetent by the general practitioner (GP), a medically indicated not for resuscitation decision was made by the GP in discussion with the enduring power of attorney (EPOA). The EPOA of the four dementia care resident files reviewed had been activated.</p> <p>The family members and residents interviewed confirmed they have been made aware of and fully understand</p>

consent.		<p>informed consent processes and that appropriate information had been provided.</p> <p>The six resident files reviewed had a signed admission agreement.</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>Residents interviewed, confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on resident's family/whānau 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>	FA	<p>Residents and relatives interviewed confirmed open visiting hours but not during the Covid-19 lockdown, they commented that the service worked to maintain communication during this time. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.</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>Complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the service. Residents interviewed confirmed they received information on the complaints process on admission and the manager is very approachable should they have any concerns/complaints. Care staff interviewed are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There were no complaints logged.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The RN or manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the</p>

		scope.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there are areas that support personal privacy for residents. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Caregivers could describe definitions around abuse and neglect that align with policy, promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Caregivers could describe how choice is incorporated into resident care.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Māori health plan references local Māori health care providers and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The service has links with Te Hīringa Huora NZ. During the audit, there were two residents who identified as Māori living at the facility, one care plan for a resident who identifies as Māori had this documented.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Individual beliefs or values are discussed and incorporated into the care plan. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff employment process includes the signing of an employment agreement that covers a code of conduct. Staff were observed to be professional when carrying out their duties. Interviews with care staff described how they build a supportive relationship with each resident. Residents and the relatives interviewed stated they are treated fairly and with respect by staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service is in the process of reviewing and updating all policies according to best practice (link 1.2.3.3). The manager and staff are committed to providing a service based on the mission statement and philosophy of care. This was observed during the day with the staff demonstrating a caring attitude to the residents. Facility meetings and a positive team culture (as described by the staff) enhance communication between the teams and provide consistency of care.</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 is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Fifteen incident forms all documented that family had been notified of the incident. Resident files reviewed, documented family communication. Relatives interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.</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>Springvale Manor Rest home provides care for up to 27 residents at rest home and secure dementia level of care (including two additional dementia level beds verified by this audit). On the day of audit there were five rest home residents in the five rest home beds and 22 residents in the 22-bed dementia unit. All residents were under the ARRC contract.</p> <p>The directors, including the wife and husband owner/operators are the governing body for Springvale Manor Limited. The manager and shareholder were able to describe the company quality goals. The company vision statement is visible on the wall at the front entrance and in the information brochures that are readily available. There is a 2020 business plan that outlines objectives for the period.</p> <p>The service is managed by a new manager (an enrolled nurse) who was the assistant manager prior to this role. The manager is experienced in elderly care management both in New Zealand and Australia. She reports to one of the directors monthly and is supported by a registered nurse (RN) who works full time Monday</p>

		to Friday. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home (sighted). The retiring manager will continue in a supporting role as needed.
<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	The registered nurse covers during the temporary absence of the manager with support from the director.
<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>	PA Moderate	<p>There is a documented quality and risk system that is not fully embedded into practice. Discussions with the manager reflected staff involvement in quality and risk management processes. Resident and relative surveys are completed with a 2020 survey yet to be collated.</p> <p>The service is in the process of reviewing and developing policies and procedures. There are a range of policies in place that comply with best practice, however, many are have not been reviewed in the last two years.</p> <p>There is a quality monitoring programme to monitor contractual and standards compliance and the quality of service delivery in the facility. There are clear guidelines and templates for reporting. The facility collects, analyses and evaluates data. There is an audit schedule, but not all audits have been completed according to timeframes. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Action plans are developed when service shortfalls are identified and followed up. However, not all quality data and outcomes have been reported to meetings</p> <p>Health and safety policies are implemented and monitored by the manager. The health and safety committee meet monthly as part of the monthly quality/staff meeting. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring, identification and meeting of individual needs.</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>	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of 15 incident/accident forms identified that forms were fully completed and include follow-up by the manager and RN. Neurological observations are completed for any suspected injury to the head. The manager was able to identify situations that would be reported to statutory authorities.</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>	PA Low	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (the RN, three caregivers, the diversional therapist and laundry person) included a recruitment process, which included reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. Health practitioner practising certificates are maintained on file.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an education and training plan that has not been implemented fully. There is an attendance register for each training session and an individual staff member record of training. The registered nurse is interRAI trained.</p> <p>The service works to assist staff with Careerforce training. Of the 16 staff who work in the dementia unit, 12 have completed the dementia unit standards, two are in the process and two new staff are being enrolled.</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>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. The RN and the manager are on site Monday to Friday. The manager and RN share on call when not on site.</p> <p>The service is staffed as one unit with the RN and senior caregiver based in the dementia unit; rosters are as follows:</p> <p>The dementia unit has twenty-two beds with twenty-two residents and the rest home with five beds and five residents.</p> <p>AM: Four caregivers on full shifts (three in the dementia unit and one in the rest home).</p> <p>PM two caregivers working 4 pm to 12 midnight (one in dementia unit and one in rest home), one caregiver</p>

		<p>working 4 pm until 11 pm and one caregiver 5 pm until 10.30 pm (both in dementia unit).</p> <p>There are two caregivers on night shift.</p> <p>Staff reported that staffing levels were not always enough (link 1.3.9.1). Residents and family interviewed, advised that they felt there is sufficient staffing.</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>	PA Low	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or clinical leader including designation. Files are not integrated.</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>	FA	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs including information on the dementia care service is provided for families and residents prior to or on admission. Prior to entry, all potential residents have a needs assessment completed by the Needs Assessment and Coordination Service, to assess suitability for entry to the service. The needs assessments for all residents were checked for correct placement as requested by the DHB. All residents were in the correct level of care within the facility with the exceptions of one resident who has been re-assessed as psychogeriatric level of care and awaiting a bed at another facility. There were two dementia care residents requiring two-person transfer that require re-assessment (link 1.3.9.1).</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet current guidelines. The RN and caregivers that administer medications have been assessed for competency on an annual basis.</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>Medications are checked on delivery by the RN and verified on the electronic medication system. All medications are stored safely. The medication room air temperature is not monitored. There were no residents self-medicating. Regular and 'as required' medications are administered from blister packs. 'As required' medications are checked monthly, however medications in the fridge had expired. All eyedrops in the use were dated on opening. The pharmacy completes a six-monthly controlled drug audit and check stock levels with delivery of medications, however there were no weekly checks of controlled drugs. There are standing order medications (household remedies) such as enerlyte and ural sachets, however there were no standing orders authorised by the GP.</p> <p>All twelve medication charts reviewed (four rest home and eight dementia care) on the electronic medication system met legislative prescribing requirements. All medication charts had photo identification and allergy status documented. The GP has reviewed the medication charts three-monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals and home baking are prepared and cooked on site. The qualified cook is supported by a second cook on her days off. Cooks are on duty from 7 am to 3 pm and are supported by tea aide. Food services staff have completed food safety hygiene and chemical safety training. There is a four-weekly menu that has been reviewed by a dietitian February 2019. The kitchen is located within the dementia unit adjacent to the dining room with a door barrier at the kitchen entrance. The cook receives a resident dietary profile and is notified if there are any changes. Diabetic diets, pureed/soft foods and dislikes are accommodated. All meals are plated at the servery. Meals are served to rest home residents in a separate dining room. There are lip plates available to encourage resident independence with meals. Nutritious snacks are available at all times from the kitchen and include sandwiches, biscuits, puddings, yoghurts, jellies and fruit. Fresh fruit and vegetable juices have been introduced for juice day Tuesdays and at other times as requested.</p> <p>There is a current food control plan. Kitchen fridges and freezer temperatures end cooked meat temperatures and cooling temperatures are taken daily and recorded. All dry goods in the pantry were date labelled. All perishable foods in fridges were date labelled. Staff were observed wearing personal protective clothing. Cleaning schedules are maintained. There are new fly screens on the external windows. Electrical equipment had been tested and tagged. The dishwasher is serviced six-monthly. Chemicals are stored safely in the kitchen storeroom.</p> <p>Rest home residents and relatives interviewed commented positively on the meals provided. Residents provide daily verbal feedback on the meals. A review if the kitchen and discussion with the cook confirmed that the kitchen was able to cater for two additional residents in the dementia unit.</p>
<p>Standard 1.3.2: Declining</p>	<p>FA</p>	<p>The admission policy describes the declined entry to services process. Springvale Manor records the reason for declining service entry to potential residents should this occur and communicates this to potential</p>

<p>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>residents/family/whānau and refers the potential resident/family/whānau back to the referral agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RN or interRAI trained care manager completes an initial assessment on admission including risk assessment tools. An initial interRAI assessment is completed (link 1.3.3.3). The RN countersigns all assessments completed by the enrolled nurse. Resident needs and supports are identified through the ongoing assessment process in consultation with resident (as appropriate), EPOA and significant others. InterRAI assessments, assessment notes and summary were in place for all long-term resident files reviewed, however not all routine interRAI assessments had been completed six-monthly (link 1.3.3.3). The long-term care plan includes triggers and assessment scores to be documented. The one current long-term care plan in place reflected the outcome of the assessments (link 1.3.5.2). Behaviour assessment tools had been completed in the files of dementia care residents.</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>Five of eight resident care plans reviewed (including two dementia care plans in the extended sample) included all categories of care and daily activities. One of the five care plans (dementia care) was current, resident focused and with identified support needs as assessed including interventions to meet resident goals. Four care plans (one rest home and three dementia care) had not been updated to meet the resident's current needs and supports including behaviour management. There were no care plans available (or could be located) for three resident files reviewed (one rest home and two dementia). Resident files for five residents on restraint were reviewed and did not include risks and interventions associated with the use of restraint. Short-term care plans are used for changes to care or health and reviewed regularly by the RN and signed off when the problem has been resolved. These were sighted for behaviour changes, infections and falls. There was no documented evidenced of resident (as appropriate) and family/whānau involvement in the care plan process, however relatives interviewed confirmed they were involved in the care planning process. Resident files included discharge summaries, allied health care professionals' letters and progress notes demonstrating involvement in the care of the resident, but care plans did not identify allied health professionals involved in the care of the resident.</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>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There was evidence (in progress notes) that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Relatives and residents interviewed stated their expectations were being met and were being kept well informed on health matters.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place (link 1.2.2.2). Wound assessments, treatment plan and evaluations (including photos and size of wounds) were in place for five dementia care residents. Wounds included three skin tears, one moisture lesion and two other lesions. There were no pressure injuries on the day of audit. There is access to the DHB wound nurse specialist if required. All residents had been assessed for pressure injury risk on admission and six-monthly as part of the interRAI assessment (link 1.3.3.3). Pressure relieving equipment is available if required.</p> <p>Contenance products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health.</p> <p>Monitoring occurs for daily hygiene checklists, bowel records, weight, observations, fluid balance, blood glucose, Abbey pain assessment/monitoring, challenging behaviour, wounds, continence and restraint. The RN reviews the monitoring charts and reports identified concerns to the GP.</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 service employs a qualified diversional therapist (DT) for 28 hours Monday to Thursday from 8 am to 3 pm. She is supported by a level 3 caregiver who is currently progressing through DT qualifications and provides activities on Fridays and at other times as available. Caregivers incorporate activities into their role. There is an activity room with plentiful resources available.</p> <p>The DT provides a weekly programme that is flexible to meet the needs of the dementia care residents and the rest home residents including daily walks or exercises, newspaper reading, board games, colouring, movies and happy hours. There is another quieter lounge in the dementia unit with a pool table. The rest home has an outdoor area and access to a neighbouring local reserve for supervised walks. There is access to safe outdoor walking pathway and gardens for dementia residents to safely wander.</p> <p>The DT has introduced an Elliptical trainer (electric foot and leg exerciser) which is shared between residents for individual exercises. The DT is in the process of developing individual resident music profiles and residents are able to listen to their music of choice through Bluetooth headphones using iPad, iPhone and iPod set up by staff. Recent activities have included (but not limited to) in the programme are Juice Day – Tuesday, Wandering Wednesday, Foot Spa days and Tournament days.</p> <p>Consent is gained from rest home residents and their families to join some activities in the dementia unit such</p>

		<p>as entertainment, church services, board games, guest speakers and outings. There is a large double lounge that can be closed off from the dementia unit (if required) to provide an entertainment area. Community visitors include monthly entertainers, monthly church services and canine friends. Visitors and the DT bring in their pets. There is one-on-one time spent with residents. Daily contact is made with rest home residents who prefer individual activities and choose which group activities they would like to attend. There are weekly van outings to places of interest or scenic drives.</p> <p>An activity assessment and a life history are completed within two weeks of admission as sighted in six resident files. A resident DT plan with individualised activities and goals had been developed and evaluated six-monthly for residents who had been at the service six months. Monthly progress notes are maintained. The DT meets with the resident (as appropriate) and relative/EPOA to discuss the activity plan.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Initial care plans for two recent admissions had been evaluated by the RN prior to the development of the long-term care plan (link 1.3.3.3). One current long-term care plan was not due for evaluation and four long-term care plans (one rest home and three dementia care) did not have an evaluation documented six-monthly. The GP reviews the residents at least three-monthly or earlier if required. There is no multidisciplinary team review sighted in the resident files for care plan evaluations. Four other care plans reviewed had not been updated with changes following the interRAI assessment (link 1.3.5.2). Short-term care plans were evaluated regularly for progress against short-term needs.</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>	PA Low	<p>Referral to other health and disability services is evident in the resident files reviewed, however there were two dementia care residents with declining mobility requiring two person transfers. The service has one resident that was referred for re-assessment of level of care and approved for psychogeriatric level of care and awaiting a bed in another facility. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets are readily accessible for staff. Chemicals sighted have correct manufacturer labels. Chemicals were stored in locked areas (sluice room,</p>

<p>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>laundry/housekeeping and food services). Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have attended chemical safety training.</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 Springvale Manor rest home building has a current building warrant of fitness that expires 22 June 2021. The building has two entrances, one at the rest home and one at the dementia care unit with secure access to the unit.</p> <p>The owner/manager contracts a mobile maintenance person for repairs and planned maintenance as per the schedule. The maintenance logbook (sighted) evidenced repairs are carried out within a timely manner. Electrical equipment has been tested and tagged. Clinical equipment has not been documented as calibrated annually. Planned maintenance includes hot water temperature monitoring, but there was no documentation around hot water testing.</p> <p>Hallways in both the rest home and the dementia care unit are sufficiently wide enough to allow residents to mobilise with the aid of walking frames and other mobility aids safely. There are plans for refurbishment including replacing carets in commons areas, updating the whānau/family room and establishing sensory herb gardens.</p> <p>The rest home residents have safe access to outdoor areas where seating and shade is provided.</p> <p>Two rooms (storage room and diversional therapy room) in the dementia unit have been converted to resident rooms. Both rooms are of a sufficient size to allow space to move around and complete cares. The rooms both had windows and adequate natural light. Call bells are in place.</p> <p>The dementia care unit has exit and entry points to the safe and secure outdoor walking pathway and garden areas, which provide seating and shade.</p> <p>The RN and caregivers (interviewed) stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. A hoist is available if required post falls.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing</p>	<p>FA</p>	<p>The five rest home rooms have a full ensuite. There is a communal toilet off the rest home lounge with privacy locks. There are sufficient numbers of communal toilets/showers in the dementia unit. Toilet and shower</p>

<p>Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>facilities are of an appropriate design to meet the needs of the residents. There are engaged/vacant signs and privacy curtains for shower rooms.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There are five large rest home rooms with space for residents' furnishings and adornments as viewed on the day of audit. All resident rooms in the dementia unit are single. There is adequate room to safely manoeuvre with mobility aids in the resident bedrooms. Residents and families are encouraged to personalise their rooms as evident on audit day.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The rest home has a separate TV lounge and a separate dining room with doors that open out onto the outdoor courtyard and gardens.</p> <p>The dementia unit has a double lounge which can be closed into two smaller lounges while maintaining safety for dementia care residents. There is a smaller quieter lounge at the other end of the unit with a pool table. There is a separate dining room for dementia care residents adjacent to the kitchen. The kitchen has safety gates in place. A hair salon is located in the dementia unit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry is located within the dementia unit and has keypad access and a locked external screen door. All personal clothing and linen are laundered on site. There is a designated laundry person seven days a week from 8.30 am to 2.30 pm. There is a defined clean/dirty flow. A separate folding/linen room</p>

<p>cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>is located outside of the laundry. All equipment has been serviced.</p> <p>There is a designated cleaner seven days a week from 9 am to 3 pm. The cleaner's trolley is kept in the laundry when not in use. There is a chemical dispensing system in the laundry for the refilling of chemical bottles. Chemicals are kept in a caddy that is taken into the rooms for cleaning. A wax machine is available. The facility was observed to be clean and tidy on the days of audit. Residents and relatives were satisfied with the laundry and cleaning service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation plan. Fire drills are held six-monthly. There are sufficient staff with current first aid certificates to cover every shift. There is a civil defence kit that is checked six-monthly. The kitchen has gas hobs and there is a BBQ for alternate cooking. There are sufficient food supplies to last three days, but not water. If required, the facility would hire a generator. There is an appropriate call bell system that works throughout the facility. There are keypads on appropriate doors in the dementia unit. In the rest home, external doors are kept locked after dusk.</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>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There are sufficient doors and opening windows for ventilation. All bedrooms have external windows which allow plenty of natural light.</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</p>	<p>PA Low</p>	<p>Springvale Manor has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the designated infection control nurse with support from the manager. The quality/staff meeting team is the infection control team. Minutes are available for staff (link 1.2.3.6). Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. There is no documented evidence that the IC programme has been reviewed annually.</p> <p>Covid 19 education has been provided for all staff, including hand hygiene and use of PPE. All visitors are required to provide contact tracing information and to wear PPE. The service had not admitted any new residents during the Covid- 19 lock down. The manager was able to describe the process for isolation if</p>

scope of the service.		needed.
<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 registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising all staff) have good external support from the local laboratory infection control team and nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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>There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by an external consultant, but have not been reviewed for the service in the last two years (link 1.2.3.3).</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education has occurred for staff. The infection control coordinator has completed infection control training. Visitors would be advised of any outbreaks of infection and advised not to attend until the outbreak has been resolved. There have been no outbreaks. Information is provided to residents and</p>

service providers, support staff, and consumers.		visitors that is appropriate to their needs and this is documented in medical records.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	PA Low	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Systems in place are appropriate to the size and complexity of the facility. Monthly infection data is collected only for infections requiring antibiotics. Surveillance of infections with antibiotics is entered onto a monthly infection summary. Outcomes and actions are discussed at quality meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. The service was able to show that urinary tract infections have decreased following staff education of additional fluids for residents. A review of infections during the audit evidenced an overall low infection rate for the service.</p> <p>There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. At the time of the audit there were five dementia care residents with a restraint (four with a lap belt and fall out chair and one resident with bedrails). There were no residents using an enabler. Residents using restraint were required to keep residents safe from falls. Strategies used to minimise use of restraint included sensor mats, early recognition of infections (UTI/chest), confusion and delirium, GP visits, distraction with activities and staff supervision. Staff have completed restraint competencies, however training around management of challenging behaviours has not occurred (link 1.2.7.5).</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. The restraint team is the RN restraint coordinator and ENs. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. Restraint consents had been completed by the RN and EPOA.</p>

service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the RN restraint coordinator in partnership with the GP, resident (as appropriate) and their EPOA. Restraint assessments are based on information, accident/incidents, staff discussion, resident/family discussions and observations. Ongoing consultation with the resident, family/whānau and GP were evident. Five resident files where restraint was in use were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions trialled before implementing restraint. The use of restraint is linked to the residents' care plans; however, there are no documented risks/interventions associated with the use of restraint (link 1.3.5.2). Monitoring is documented on a specific restraint monitoring form, evidenced for the five resident files where restraint was being used. The type of restraint used, when required has a time on and time off recorded as well as the restraint checks as per the documented frequency. Written checks include supports/needs provided during the episode of restraint such as position change, food and fluids and toileting. A restraint register is in place providing a record of restraint use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted six-monthly. A review of the five resident files identified that evaluations were up to date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Staff meeting minutes record the number of restraints only and do not include discussion or review of restraint use (link 1.2.3.6). Internal restraint audits measure staff compliance in following restraint procedures. A review of accidents/incidents identified there had been one fall when a restraint had not been in place.</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 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	The service has a range of policies and procedures in place, however not all had been reviewed and up to date. The manager has recognised this issue and is currently working through a review and update process of all policies.	Policies have not been reviewed and updated within reasonable timeframes examples include sexuality (2015), infection control (2012) and pressure injury (2003).	<p>Ensure that there are a range of up to date polices to comply with the ARRC contract and best practice.</p> <p>90 days</p>

<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Low</p>	<p>The service has a documented quality system. The system has not been embedded into practice. The service is small, and the manager and RN monitor the service on a daily basis.</p>	<p>Not all quality data analysis and outcomes are reported at meetings, this included health and safety information and restraint review information</p>	<p>Ensure that all quality information is reported to the quality/staff meetings</p> <p>90 days</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>PA Low</p>	<p>The service has a business review and forward strategy that includes some business objectives such as staff development and setting up an improved quality programme. This plan does not include clear and timebound objectives. Discussion with the manager evidenced that the service has clear plans to improve the service such as embed the quality system, improve the environment and also include clinical objectives.</p>	<p>(i). The quality plan/business plan does not include clear and timebound objectives to enable evaluation of progress.</p> <p>(ii). Internal audits have not been completed according to timeframes</p>	<p>(i). Ensure that there are set and timebound goals/goals for the service (SMART objectives).</p> <p>(ii). Ensure the internal audit timeframes are complied with</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>The manager has recognised the need for a robust training programme and has planned a programme for the future. Staff training over the last two year has not aligned with the requirements of the ARRC contract. Advised that training modules have not yet been updated and training material reviewed. Since the draft report, the manager advised there have been several training sessions postponed due to COVID social distancing requirements and temporary non availability or cancelling of guest speakers/organised education sessions. Advised that all training subjects are integrated, refresher</p>	<p>The service has not provided all training as required by the ARRC contract over the last two years. Training not completed includes resident rights, advocacy / open disclosure, sexuality, pain management, privacy / dignity, and aging process.</p>	<p>Ensure that a training programme for staff is implemented that complies with the ARRC contract.</p> <p>90 days</p>

		toolbox sessions organised, and questionnaires handed out at orientation and as part of competency review. The ageing process module has been completed recently by all level 2 and level 3 staff with training agreement as part of achieving /gaining certificates.		
Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.	PA Low	Each resident has a hard copy file kept in the nurses' station. The files include admission details, consents, advance directives, GP notes, allied health professional letters, interRAI assessments and observation records. The index also lists short-term care plans and long-term care plans. There was a separate wound care folder, short-term folder and monitoring forms and separate progress notes.	The resident files were not integrated with separate folders. All original short-term care plans and progress notes are stored in residents' files. There are separate folders for current progress notes only and a "daily documentation file. Long-term care plans were not available in the resident file and were not readily available to staff. Three resident files did not have care plans in place. Since the draft report the manager has provided copies of missing care plans.	Integrate resident files to include all service delivery records for the resident. 180 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in	PA Moderate	Medications were stored safely. Regular and as required medications were prescribed correctly on the electronic medication charts; however, there were no GP instructions for use of standing orders. Medications are reconciled on delivery and 'as required' medications checked for expiry dates, but medications in the medication fridge had expired. The pharmacist completes a six-monthly controlled drug stocktake and delivers controlled drugs as recorded in the controlled drug register, however there are no weekly controlled drug checks completed. The medication room is secure and has a window covered by a security screen, but there is no monitoring of the medication room air	(i) The three medications (glucagon and eye drops) kept in the fridge had expired. (ii) There were no standing orders in place authorised by the GP including the indications, contra-indications, timeframes and monitoring requirements for use. (iii) There were no weekly controlled drug checks completed. (iv) There was no monitoring of medication room air temperatures.	(i) Ensure medications in the medication fridge are checked for expiry dates. (ii) Standing orders to comply with standing medication requirements. (iii) Ensure weekly controlled drug checks are completed by an RN and one other medication competent

order to comply with legislation, protocols, and guidelines.		temperatures.		person. (iv) Ensure the medication room air is monitored. 30 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	All resident files evidenced an initial assessment and initial care plan completed within 24 hours of admission. InterRAI assessment had been completed for all resident files (including the two interRAI assessments reviewed due to an extended sample), however two first interRAI assessments and two routine interRAI assessments had not been completed within the required timeframes. Two long-term care plans completed for new admissions had not been completed within three weeks of admission. One long-term care plan (dementia care) was current but one rest home and three dementia care long-term care plans had not been evaluated six-monthly. Three resident files (one rest home and two dementia care) did not have care plans in place.	(i) Two initial interRAI assessments (one rest home and one dementia care) were not completed within 21 days of admission. (ii) Two long-term care plans (one rest home and one dementia care) had not been developed within three weeks of admission. (iii) Two routine interRAI assessments from the extended sample (dementia care) were not completed six monthly or earlier due to health change. (iv) Four long-term care plans reviewed (one rest home and three dementia care), including the extended sample, had not been evaluated six monthly or earlier due to health changes. v) There were no long-term care plans for three residents (one rest home and two dementia care).	(i) Ensure initial interRAI assessments are completed within 21 days of admission. (ii) Ensure long-term care plans are developed within three weeks of admission. (iii) Ensure routine interRAI assessments are completed six monthly or earlier for health changes. (iv) Ensure all long-term care plans are evaluated six monthly or earlier due to health changes. (v) Ensure all residents have long-term care plans in place. 60 days
Criterion 1.3.5.2 Service delivery plans describe the required	PA Moderate	A total of eight care plans were reviewed as sample size extended to review currency of long-term care plans. Of the four care plans available, one dementia care plan was current and met the residents needs and supports including behaviour	(i). Four care plans (one rest home and three dementia care) had not been updated to meet the resident's current needs and supports as follows: a) there were no documented interventions for a	(i) Ensure care plans are updated to reflect the resident's current needs and supports.

<p>support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>management. InterRAI assessments identified and triggered risks and required needs and supports to be care planned, however not all care plans had been updated and in three files, long-term care plans were not able to be located. The risks of restraint use as identified on the restraint assessment had not been documented in care plans.</p>	<p>rest home resident with cardiorespiratory problems and osteoarthritic pain as identified in the interRAI assessment, b) there were no documented interventions for one dementia care resident assessed as high falls risk and risk of undernutrition, c) there were no documented interventions for one dementia care resident with changes to mobility and nutrition with weight loss and, d) another dementia care resident with changes to mobility and nutritional needs.</p> <p>(ii). There were no behaviour management plans in place that described the behaviour, triggers, de-escalation and alternative strategies for distraction including activities in all four dementia care files.</p> <p>(iii). There were no long-term care plans in place for three residents (one rest home and two dementia care).</p> <p>(iv). There were five residents with restraint in use as required. There were no risks associated with the use of the restraint documented in the care plans.</p>	<p>(ii) Ensure all residents with dementia have a 24-hour behaviour management plan in place.</p> <p>(iii) Ensure all residents have a current long-term care plan.</p> <p>(iv) Ensure the risks associated with the use of restraint is documented in long-term care plans.</p> <p>60 days</p>
<p>Criterion 1.3.5.3 Service delivery plans demonstrate service integration.</p>	<p>PA Low</p>	<p>Long-term care plans are developed by the RN or EN (countersigned by the RN) however there is no documented evidence of resident/relative input into care planning. The relatives interviewed stated there were discussions with the RN or EN around their relative's care plan. There were letters and progress notes of allied health professionals in the</p>	<p>(i) Five of eight care plans reviewed (there were no care plans for three residents) did not document resident (as appropriate) or relative/EPOA input into the care plan.</p> <p>(ii) The long-term care plans did not include the involvement of allied health</p>	<p>(i) Ensure there is documented evidence of the resident/relative involvement in the care plan.</p> <p>(ii) Ensure involvement of allied health</p>

		resident files demonstrating involvement in the resident's care; however, this is not linked to care plans. Care plans viewed did not include the involvement of allied health professionals in the care of the resident (also link 1.2.9.10)	professionals in the care of the resident.	professionals are linked to the long-term care plan. 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Previous written evaluations sighted, documents the resident's progress against identified goals and states the EPOA/relative involved in the evaluation, however these documents had not been dated within the last six months. One dementia resident long-term care plan was not due for evaluation.	There was no six-monthly written evaluation for four of eight long-term care plans (one rest home and three dementia care).	Ensure care plans are evaluated at least six-monthly for progress towards meeting the desired goals. 90 days
Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.	PA Low	There were a number of referrals sighted in resident files reviewed including (but not limited to) mental health services for older persons, consultant psychiatrist, district nurse, retinal screening and the needs assessment and coordination team. One dementia care resident had been re-assessed for a higher level of care. Two residents with declined health had not been referred for reassessment. There was also one resident approved for psychogeriatric level of care awaiting a bed in another facility. Since the draft report the manager advised that this resident has transferred out.	There were two dementia care residents with declining mobility that required at times two person transfers and feeding as confirmed by caregivers and the RN on interview. These residents had not been referred for reassessment.	Ensure referrals are made to the needs and assessment team for residents with declining mobility and health. 90 days

<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	The manager described a maintenance schedule, and stated that the owner would always ensure that equipment was purchased as needed and or repaired. The calibration of equipment and documenting of hot water temperatures was not able to be evidenced.	<p>(i) The annual calibration of equipment has not been documented for 2020.</p> <p>(ii) Hot water temperature monitoring was not able to be evidenced.</p>	<p>(i): Ensure that the calibration of equipment is documented annually</p> <p>(ii). Ensure that hot water temperature monitoring is documented.</p> <p>90 days</p>
<p>Criterion 1.4.7.4</p> <p>Alternative energy and utility sources are available in the event of the main supplies failing.</p>	PA Low	The service has civil defence stores and a business continuity plan. There is water stored for an emergency, however the total amount of water does not comply with the civil defence guidelines for the area.	There is not enough water stored for three litres per person per day for three days as required for this area	<p>Ensure there are sufficient water supplies stored.</p> <p>90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Low	There is a well-documented infection control policy (link 1.2.3.3). The policy describes an annual review. The service has not documented an annual review.	The infection control programme has not been reviewed annually.	<p>Ensure an annual review of the infection control programme is documented.</p> <p>180 days</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations</p>	PA Low	The surveillance policy describes the process for infection data collection which aligns with IC definitions. However not all infections are collected, only those with antibiotic treatment.	Only infections that are treated with antibiotics are collected as infection data.	Ensure that all infections are collected as per the service policy.

<p>to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>				<p>90 days</p>
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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.