

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

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Villages of New Zealand (Pakuranga) Limited
<b>Premises audited:</b>	Park Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 9 June 2021    End date: 9 June 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	37

# Executive summary of the audit

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## 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

Park Rest Home provides rest home and hospital level care for up to 40 residents. The service is one of four facilities owned and operated by Real Living Group, which Villages of New Zealand (Pakuranga) Limited is a member of, and is privately owned. The care facility is attached to the village complex and is managed by a village manager. The village manager reports to the Chief Executive Officer (CEO). The care services are managed by a clinical manager who is supported by a clinical coordinator. A clinical manager for Real Living Group oversees all four facilities and is responsible for quality management.

This surveillance audit was conducted against the Health and Disability Services Standards and the services contract with Counties Manukau District Health Board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, management, allied health, staff and a general practitioner.

This audit has resulted in three new areas identified as requiring improvement in relation to the document control system, temperature control of the medication room and the menu plans not being reviewed by a registered dietitian in the required timeframe. The three areas identified from the previous audit have been fully addressed.

## 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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Open disclosure and communication between staff, residents and families is prompted and was confirmed to be effective. There is access to interpreter services if required.

A complaints register is maintained electronically with complaints resolved promptly and effectively.

## 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 quality and risk management plan includes the scope, direction, objectives, values and philosophy of the organisation. Monitoring of the services provided to the governing body is regular and effective. The village manager and the clinical manager are both new to their roles since the previous audit. Member of the management team are qualified to undertake their roles.

The quality and risk management system includes collection and analysis of quality improvement data, identifies any trends and leads to improvement. Staff are involved and feedback is provided at the staff and quality meetings. A resident/family survey is

completed in December each year. Adverse events are documented with corrective actions being completed and signed off by management. Actual and potential risks, including health and safety risks are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. Ongoing training supports safe service delivery and includes regular annual staff appraisals being performed. Staffing levels and skill mix meet the changing needs of residents.

## 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 low risk.
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The Needs Assessment Service Coordination (NASC) team assesses residents before entry to confirm the level of care required. Assessments and care plans are completed and evaluated by the nursing team. Short-term care plans are developed for all short-term problems, and these were verified in records sampled.

Activities plans are completed by the registered nurses (RNs) and the diversional therapist (DT). The activities programme is developed in consultation with family/whanau and residents noting activities of interest. Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management policy in place. The organisation uses an electronic system in e-prescribing, dispensing, and administration of medications. Staff involved in medication administration are assessed as competent to do so.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for.

## Safe and appropriate environment

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

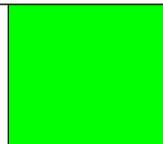


Standards applicable to this service fully attained.

There is a current building warrant of fitness.

## Restraint minimisation and safe practice

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



Standards applicable to this service fully attained.

The organisation supports a restraint free environment. Five enablers were in use and no restraints at the time of the audit. Use of enablers is described in policy as voluntary and the least restrictive in response to individual requests from residents. Staff interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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>Standards applicable to this service fully attained.</p>
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The infection control surveillance and associated activities are appropriate for the size and complexity of the service and are carried out as specified in the infection control programme.

## 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	13	0	2	1	0	0
Criteria	0	36	0	2	1	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The residents and family members interviewed stated that information was provided on admission and they knew how to access the forms if needed.</p> <p>The village manager is responsible for the complaints management. The clinical manager Park Rest Home is responsible for promptly and appropriately investigating and managing complaints, alongside the village manager. The complaints register is maintained by the personal assistant/secretary. The complaints register showed that there had been four written complaints in the last twelve months. The clinical manager confirmed that if a complaint is received action was commenced through to an agreed solution. This process is documented to include all required follow-up. Staff interviewed confirmed a sound knowledge and understanding of the complaints/compliment process and what actions are required. There have been no complaints received from any external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Residents and family members interviewed stated that they were kept well informed about any changes to their/their relative's health and wellbeing and were advised in a timely manner about any incidents or accidents that occurred. Should any emergency admissions or medical reviews be required the family were contacted. Staff interviewed understood the principles of open disclosure which is supported by policy and procedures that meet the requirements</p>

effectively with consumers and provide an environment conducive to effective communication.		<p>of the Code of Health and Disability Services Consumers' Rights.</p> <p>Staff interviewed knew how to access interpreter services if required. Staff are able to provide translation and act as an interpreter as and when needed, if required and appropriate.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The service has a business plan. The village manger interviewed stated that regular communication occurs between the board of directors, the village manger, clinical manager and the owners. The quality plan was sighted and this provides a quality statement, mission statement and organisational philosophy. Objectives of service delivery are documented. Annual and longer term objectives and associated operational plans are documented. The clinical manager reports to the village manager on a monthly basis and monthly reports were reviewed. In addition to this, the clinical manager reports to the clinical manager Real Living Group three monthly.</p> <p>There has been some changes since the previous audit in relation to the appointment of a new clinical manager, a clinical coach and resource nurse part-time (48 hours/week), and a clinical coordinator. The previous clinical manger now has the position of clinical manager Real Living Group and covers/oversees four aged care facilities within this organisation. The clinical manager Real Living Group is responsible for the complaints mangement and quality management for the organisation. The clinical manager and coordinator were available on the day of the audit.</p> <p>The clinical manager is an experienced registered nurse who has been recently employed in this role and is responsible for the day to day running of the services provided. The clinical manager reports to the village manager who also has been recently appointed to this position. The village manager interviewed reports any concerns to the board of directors and monitors the care facility performance including financial performance, any emerging risks and/or any issues. Responsibilities and accountabilities were defined in job descriptions reviewed and individual employment agreements. The members of the management team confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through regular ongoing education related to their roles.</p> <p>The service holds contracts with the Counties Manukau District Health Board (CMDHB) for rest home level care including respite care and hospital level care (since 02 November 2020). In addition to this, they have contracts for primary options for acute care (POAC) and mental health. On the day of audit there were 37 residents receiving care; 29 rest home, eight hospital (including the one mental health hospital level care resident). There were no residents receiving care under the POAC contract and no residents receiving respite care.</p>
Standard 1.2.3: Quality And Risk Management	PA Moderate	<p>The organisation has a quality and risk plan which details the risk, current controls and ongoing action required. The residents are the prime focus in planning, delivery and evaluation of services. Goals and objectives are outlined. Risk mangment is defined and categorised. This includes management of incidents and complaints and internal</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections, restraint minimisation and safe practice and accident and incident reporting.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff and quality meetings as appropriate. The village manger has a close working relationship with the board of directors and the owners. Staff reported their involvement in quality and risk management activities through audit activities, review of statistical quality data and corrective action followup. Relevant corrective actions are developed and implemented by the clinical manager to address any shortfalls with the outcomes evaluated prior to sign off.</p> <p>Resident and family satisfaction surveys are completed annually, the last being completed in December 2020. The results evidenced residents were satisfied with all service provision. Any additional comments were followed up by the clinical manager.</p> <p>The policies and procedures for all areas of service delivery are under review, and in particular the clinical policies since the hospital level care contract was commenced in November 2020. Policies and procedures were all outdated except for a couple of manuals which have been updated recently. This is work in progress; however, there are new staff employed and they are reliant on the policies being reviewed to guide them in addition to their job descriptions and responsibilities outlined. The quality manual, for example, has not been reviewed since 2017. Additional administrative resource is currently being reviewed to ensure that updated documents are formatted and filed in a timely manner. As an interim measure, an administrator is now closely working with the clinical manager Real Living Group to print and file updated documents in the hard copy folders as soon as possible.</p> <p>The clinical manager interviewed described the processes for the identification, monitoring, review and reporting of any risks and development of mitigation strategies. The clinical manager is up to date with the Health and Safety at Work Act (2015) and has implemented requirements.</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</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms, now recorded online in a monthly log, were fully completed, incidents were investigated, action plans developed and actions followed up in a timely manner. Adverse event data is collated, analysed and reported to the clinical manager, clinical manager Real Living Group and to the village manager. Significant events are reported to the board of directors immediately as required or as per the reporting system in place.</p> <p>The clinical manager described essential notifications reporting requirements including for pressure injuries. One Section 31 notice has been completed since the previous audit in relation to key staff changes. There have been no police investigations, coroner's inquests, issues based audits and any other notifications.</p>

<p>where appropriate their family/whānau of choice in an open manner.</p>		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies and processes are based on good employment practice and relevant legislation (refer to CAR 1.2.3.4). The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records were reviewed and the records are maintained to a high standard inclusive of staff education completed by each individual staff member. The individual employment contracts and job descriptions were visible in the records.</p> <p>Staff orientation is comprehensive and includes all necessary components relevant to the role. Staff interviewed reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review completed annually.</p> <p>Continuing education is planned annually and includes all mandatory educational requirements. The education and training calendar is available for staff. Staff are also linked into the electronic learning system utilised by CMDHB staff and community services are welcome to use this for ongoing learning opportunities.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. There are nineteen caregivers and 14 have completed level 4, one is at level 3 and four have not completed any levels currently.</p> <p>Five registered nurses including two in management have completed their competencies to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals by the clinical manager. All registered nurses are enrolled in the professional development and recognition programme at CMDHB. This is a new initiative introduced by the clinical manager.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery to cover the service 24 hours a day, seven days a week. The clinical manager stated that the staffing levels are adjusted to meet the changing needs of residents. Staff interviewed reported that good access to advice is available. There is an after hours on-call system which works effectively with the clinical manager and the clinical coordinator covering alternate weeks. The village manager is also on call for non-clinical issues should this arise. Team work is encouraged. Staff interviewed also stated that there were adequate staff available to complete the work allocated to them. Agency staff are used if needed. Most vacant shifts are covered by existing staff. At least one staff member on duty has a current first aid certificate. In the event of a village resident summoning assistance, a specific staff member is allocated to respond to the village call bells. This still ensures coverage on the care floor and meets the contractual requirements.</p>

		<p>An area of improvement identified in the previous audit related to the requirement to increase the registered nurses to cover the service adequately at the time of the audit and for the plan to change to providing hospital level care to residents. Registered nurses would be required to cover the service twenty four hours a day, seven days a week. This area of improvement has been fully addressed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medication charts sampled complied with legislation, protocols, and safe practice guidelines. Medication reconciliation is conducted by the nursing team when the resident is transferred back from the hospital or any other external appointments. The organisation uses an electronic medication management system. All medications were reviewed every three months and as required by the attending GPs. Allergies were indicated, and photos current for easy identification.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. The RNs were observed administering medication following the eight rights of medication administration in their respective wings. Medications were stored safely and securely in the locked cupboards and treatment rooms.</p> <p>The controlled drug register was reviewed and found to be current and correct. Weekly and six-monthly stock takes were conducted. There was one resident self-administering inhalers at the time of the audit who has been assessed as competent to do so. Administration records were maintained, and medicines were stored in a secure place.</p> <p>The previous corrective action relating to the GPs not signing verbal phone orders was corrected. The service transitioned from a paper-based to an electronic medication management system.</p> <p>Records of fridge temperature monitoring were sighted; however, medication room temperatures were not being completed.</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</p>	PA Low	<p>The kitchen service is run by the head chef and two other chefs supported by the kitchen hands. Meal services are prepared on-site and served in the respective dining areas. The food control plan was current and expires on 15 December 2021. The kitchen staff have current food handling certificates. Diets are modified as required and the head chef confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. The resident's weight is monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges, and freezers are maintained. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. The residents and family/whanau interviewed</p>

<p>delivery.</p>		<p>indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p> <p>The previous area requiring improvement relating to kitchen staff training has been addressed.</p> <p>Evidence of menu review by the registered dietitian was not sighted on the day of the audit.</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>Documented interventions in the service delivery plans were relevant to address the assessed needs and desired goals/outcomes. All significant changes were reported in a timely manner. The GP reported that communication was conducted transparently, medical input was sought in a timely manner that medical orders were followed, and care was person-centred. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources was available, suited to the levels of care provided and following the residents' needs, including for YPD residents.</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>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by the diversional therapist (DT) who has been working at the service for over 15 years in various roles. The other role for the activities person is currently under recruitment. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. A resident profile is completed for each resident within two weeks of admission in consultation with the family. Weekly activities planners are displayed on various notice boards at the facility and individual copies were given as requested.</p> <p>The activity programme is formulated by the DT. The activities are varied and appropriate for residents assessed as requiring rest home, hospital level of care, and for young people with disabilities. The sighted weekly activity programme had the following activities: garden walks; music; brain exercises; word search; bus trips; tai chi; one on one activities; the celebration of national and world events. Residents' activities care plans were evaluated along with long-term care plans and interRAI assessments.</p> <p>An activity attendance list is completed daily for each resident. The residents were observed participating in a variety of activities on the audit day. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family members and residents expressed satisfaction with the activities programme in place.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is documented on each shift by care staff in the progress notes. All noted changes by the health care assistants were reported to the nursing team in a timely manner.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response about desired outcomes and goals, occur every six months or sooner if residents' needs change. The evaluations are carried out by the RNs in conjunction with family, residents, GPs, and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan.</p> <p>Short-term care plans were reviewed regularly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family members were included and informed of all changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current building warrant of fitness displayed at reception dated 12 March 2022 (Expiry). A few internal alterations were required in the care suite with the changes needed to providing hospital level care and these were followed up by the DHB. No changes to the fire evacuation scheme were required.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. The clinical manager (CM) is the infection prevention and control coordinator. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GPs are informed within appropriate time frames when a resident has an infection and antibiotics are prescribed to combat the infection, as required.</p> <p>There have been no infection outbreak reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers should they be required. The facility operates a restraint free environment. Enablers are the least restrictive and are used voluntarily at the resident's request. On</p>

Services demonstrate that the use of restraint is actively minimised.		the day of the audit, no residents were using restraints. Five enablers were in use for mobility purposes only. Restraint would only be used as a last resort when all alternatives have been explored. Staff/quality meeting minutes showed that they continue to promote a restraint free environment at Park Rest Home.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	<p>PA Moderate</p>	<p>The document control system consisted of a signed and dated page to verify all policies had been reviewed annually. The clinical manager Real Living Group is now responsible for the quality management and documentation control. The document control records had not been signed off for the last two years. The policies and procedures reviewed were not current to guide staff. The dates on policies were 2015 and 2017. Two manuals of six reviewed had been reviewed in a timely manner. The current clinical policies do not fully align to having hospital level care residents in the facility.</p>	<p>The policies and procedures reviewed in the hard copy manuals are not current and/or are available to service providers. In addition to this the clinical manuals do not adequately align with additional care and management required for hospital level residents.</p>	<p>Ensure the document control system is developed and implemented to meet the requirements of the system including date of policy review, updated referencing, signed off by whom and when next due for review.</p> <p>180 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>Fridge temperature monitoring was completed for the medicine refrigerators in the two medication rooms at the service and any deviations from normal were being reported and corrective actions implemented where necessary. Medication room temperatures were not being monitored and documented. The location of both rooms have very minimal ventilation and staff reported that they sometimes use fans in hot temperatures.</p>	<p>Temperature monitoring for the two medication rooms at the service were not being completed as per legislation, protocols, and guidelines.</p>	<p>Ensure medication room temperatures are being monitored and recorded.</p> <p>60 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Low</p>	<p>There is a four-weekly cycle menu for the residents which includes the summer and winter menu. There was no evidence presented to show that the menu was reviewed by the registered dietitian in the last two years. There was no evidence sighted of when menu was last reviewed previously. The head chef reported that menu was regularly reviewed by the kitchen staff in consultation with residents and also following concerns raised from residents' meetings.</p>	<p>There was no evidence of the menu having been reviewed by a registered dietitian.</p>	<p>Provide evidence of menu review by the registered dietitian to ensure it complies with recognised nutritional guidelines.</p> <p>60 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.