

# Experion Care NZ Limited - Woodfall Lodge Home and Hospital

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Experion Care NZ Limited
<b>Premises audited:</b>	Woodfall Lodge Home and Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 1 July 2021      End date: 2 July 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>	23

# 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

Woodfall Lodge Home and Hospital provides rest home and hospital level care for up to 38. There were 23 residents residing at the facility on audit days.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the district health board. The audit process included the review of policies and procedures, review of resident and staff files, and observations and interviews with residents, family members, management, staff, and a nurse practitioner.

The residents and family members spoke positively about the care provided.

There were seven areas identified as requiring improvement related to: communication, ongoing staff education, service delivery, medication management, menu management, environment, and the call bell system.

## 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.

Some standards applicable to this service partially attained and of low risk.

Information regarding the Health and Disability Commissioner's code of Health and Disability Services consumers' Rights, the complaints process, and the Nationwide Health and Disability Advocacy Service is accessible. This information is brought to the attention of residents and families on admission to the facility. Residents and family members confirmed their rights are being met; staff are respectful of their needs and communication is appropriate.

The residents cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent is practised, and written consent is gained when required. Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

There are policies and procedures about the management of complaints that align with Right 10 of the Health and Disability Commissioners Code of Health and Disability Services Consumers' Rights.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Experion Care NZ Limited is the governing body and is responsible for the services provided at this facility. The mission, vision, and values of the organisation are documented and communicated to all concerned. There are systems in place for monitoring the services provided, including regular monthly reporting by the general manager to the Experion Care Services support office.

The facility is managed by an experienced and qualified general manager who has aged care experience and they have been in this position since October 2020. The general manager is supported in the role by a clinical nurse manager, who is a registered nurse and is responsible for the oversight of the clinical services in the facility.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented on accident/incident forms. Facility meetings are held where there is reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

There are policies and procedures on human resource management. A mandatory education programme is provided for staff.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice.

Resident information is entered into a register in an accurate and timely manner. The privacy of resident information is maintained. The name and designation of staff.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for the assessment, development, and evaluation of care plans with input from the residents, staff, and family member representatives. Care plans are individualised and based on the residents' assessed needs and routines. Interventions are appropriate and evaluated as required.

Planned activities are appropriate to the residents' assessed needs and abilities. The activities programme is developed in consultation with family/whanau and residents, focussing on activities of interest. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management system in place and medicines are administered by staff with current medication competencies. All medicines are reviewed by the nurse practitioner every three months and whenever necessary.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. Nutritional snacks are available for residents 24 hours a day when required.

## 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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The building has a current building warrant of fitness displayed. There is a reactive and preventative maintenance programme, and this includes equipment and electrical checks.

Residents' bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids, and to allow for care to be provided. Lounges, dining areas, and sitting alcoves are available for residents and their visitors. External areas and gardens are safe for residents to mobilise.

Security systems and cameras are in place with regular fire drills completed.

Protective equipment and clothing is provided and used by staff. Chemicals are stored. The laundry service is conducted on site. Cleaning of the facility is conducted by housekeeping staff and monitored for effectiveness.

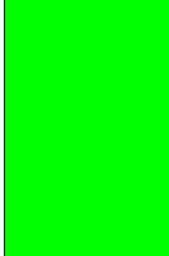
## Restraint minimisation and safe practice

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 organisation has implemented policies and procedures that support the minimisation of restraint. One restraint was in use at the time of audit. A comprehensive assessment, approval, and monitoring process with regular reviews occur. The use of enablers

is voluntary for the safety of residents in response to individual requests. No enablers were in use during the audit, Staff demonstrated 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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Infection control management systems are in place to minimise the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating the education and training of staff. Documentation evidenced that relevant infection control education is provided to staff.

Infection surveillance data is collated monthly, analysed, and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infections is 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)
<b>Standards</b>	0	43	0	5	2	0	0
<b>Criteria</b>	0	93	0	5	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies, procedures and processes are in place to meet the obligations in relation to the Code of Health and Disability Services Consumers Rights (the Code). Staff interviewed understood the requirements of the Code. Staff were respectful of residents' rights as observed in their communication with residents and family members; encouraging residents' independence: and maintaining residents' dignity and privacy. Training on the Code is included in the staff orientation process and part of ongoing training.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The informed consent policy guides staff in relation to informed consent and staff interviewed understood the principles and practice of informed consent.</p> <p>The residents' files evidenced documented consents using the organisations standard consent form that includes consent for photographs, outings, and collection and sharing of health information. Consent is also obtained on as-required basis, such as for influenza vaccinations.</p> <p>There was evidence of advanced directives signed by the residents. Residents confirmed they were supported to make choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with their relative and consulted when treatment changes were being considered.</p>

		Staff were observed gaining verbal consent for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. Staff demonstrated understanding of the advocacy service, with contact details for the service readily available at the facility.  Residents are provided with information on the advocacy service as part of the admission process. Residents and family members confirmed their awareness of the service and how to access this.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to maintain their community interests and networks, and to visit their families. The activities programme includes regular outings in the facility's mobility van and participation in community events. Community groups and entertainers also visit the facility.  The service welcomes visitors and has unrestricted visiting hours. Family members advised they feel welcome when they visit.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Policies and procedures relating to complaints management are compliant with Right 10 of the Code. Systems are in place that ensure residents and their family are advised on entry to the facility of the complaint process and the Code. The complaints forms are displayed and accessible within the facility. Staff interviewed confirmed their awareness of the complaints process. Residents and families demonstrated an understanding and awareness of these processes.  The general manager (GM) is responsible for complaints management. The review of the 2021 register noted seven complaints. This included verbal and written complaints. The register noted each complaint was investigated and letters of acknowledgement send as per the Code timeframes. Recommendations and action plans open when required and followed up in a timely manner. All complaints are closed.  One reported complaint via the district health board regarding cleanliness of the facility has been followed up and actioned and is now closed.  There are no complaints with other external agencies.

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>During the admission process, new residents and their family are given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service. Posters on the Code are displayed in English and te reo Māori at the facility.</p> <p>Residents and family members interviewed were familiar with the Code and the advocacy service. Residents and family stated they would feel comfortable raising issues with staff and management.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Staff communicated their knowledge about the need to maintain residents' privacy and were observed doing so throughout the audit.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and outings, confirmed at residents and family interviewed. Residents care plans include documentation relating to residents' abilities and strategies to maximise independence. Residents' records sampled confirmed that residents' individual cultural, religious, social needs, values, and beliefs were identified, documented, and incorporated into their care plan.</p> <p>The policy on abuse and neglect was understood by staff interviewed, including what to do should there be any signs. Education on abuse and neglect is part of the staff orientation programme and in the mandatory staff study days.</p> <p>The residents and their families confirmed they received services in a manner that has regard for their dignity, privacy, spirituality, and choices.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has a Māori Health Plan that guides staff in meeting the needs of the residents who identify as Māori. Any additional cultural support, if required, would be accessed locally, confirmed at registered nurse interview. At the time of the audit there were three staff members and one resident who identified as Māori. The review of their clinical file and interview confirmed their individual cultural needs were being met.</p> <p>Family/whānau are able to visit their family members at the facility and are part of the care planning and evaluation care process. Interviews with family confirmed they were informed of their family member's changes in condition when this occurred.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And</p>	<p>FA</p>	<p>The individual preferences, values and beliefs of residents are documented in the care plans reviewed. Residents and family members stated they had been consulted about residents'</p>

<p>Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>individual ethnic, cultural, spiritual values and beliefs, and confirmed that these were respected.</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>Residents and family members stated that residents were free from any type of discrimination or exploitation.</p> <p>Staff are guided by policies and procedures and communicated understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. Staff orientation includes information related to all forms of discrimination and exploitation, professional boundaries and expected behaviours.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Woodfall Lodge implements Experion Care policies and procedures which are based on current legislation and relevant guidelines and have been provided by an external contractor.</p> <p>The service encourages and promotes good practice through input from external specialists and allied health professionals for example, podiatrist, and physiotherapists</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>PA Low</p>	<p>A review of incident/accident forms showed timely communication with residents and or family members. Communication with family members is also recorded in the residents' files. The residents and family members stated they were kept informed about any changes to their own or their relative's status and were advised about incidents or accidents and the outcomes of medical reviews. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interviews with family and meeting minutes did not evidence relevant information is shared.</p> <p>Interpreter services can be accessed via the district health board or Interpreting New Zealand when required. This information is also provided to residents/families as part of the information/admission pack.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation</p>	<p>FA</p>	<p>Woodfall Lodge is part of the Experion Care New Zealand Ltd (EC). A general manager (GM) oversees the management of this facility and one other facility in the EC group. The GM</p>

<p>ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>provides regular emails and copies of all meeting minutes to the EC director who currently resides overseas.</p> <p>There is a clear mission of the organisation with values and goals, and these are communicated to residents, and family through posters at the entrance to the facility.</p> <p>The GM is responsible for the overall management of the service and has been in this role since October 2020. The GM has experience in management of residential care facilities, however, has resigned from this current position. Has accepted a consultancy contactor position to monitor both sites one day per week.</p> <p>The GM is supported by a clinical nurse manager (CNM) who is responsible for the oversight of clinical services. The CNM is an RN with experience in aged residential care. The CNM has been in the role since 17th May 2021. The required authorities have been informed of the appointment of the CNM.</p> <p>The facility can provide care for up to 38 residents, with 23 beds occupied at the audit. This included 10 residents requiring rest home level care and 13 requiring hospital level care. There were no residents under the age of 65 years. 36 rooms have been approved as dual purpose and two rooms for rest home level care only.</p> <p>The facility includes hospital and rest home level services and a complimentary specific contract with the local district health board.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the GM is absent the CNM and administration personal will carry out required duties under delegated authority supported by a registered nurse. Other experienced managers from sister EC facilities can be called in to provide cover and oversight if required.</p> <p>Staff and management interviewed reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>Woodfall Lodge uses the Experion Care NZ Limited quality and risk management framework that is documented to guide practice.</p> <p>The service implements organisational policies and procedures to support service delivery, including policies on InterRAI. All policies are subjected to reviews as required with all policies current. Policies are linked to the Health and Disability Sector Standards current and applicable legislation and evidenced-based practice guidelines. Policies are readily available to staff. New</p>

principles.		<p>and revised policies are presented to staff to read and sign to evidence that they have read and understood the policy at meetings.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, key performance indicators, and implementation of an internal audit programme. The GM discussed to date there is no benchmarking against other EC facilities. The review of the quality management data evidenced the 2020 patient satisfaction survey was not available and the 2021 was only completed 28th June 2021. Therefore, this was not collated and analysed to enable corrective actions to be documented or implemented. (refer to 1.1.9.1).</p> <p>Facility meetings are conducted, and minutes evidenced communication with staff around aspects of quality improvements and risk management. Staff reported that they are kept informed of quality improvements.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. The GM described the process for the identification, monitoring, review and reporting of risks. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed, and risks are minimised or isolated.</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>Staff understood the adverse event reporting process and were able to describe the importance of recording near misses. Staff are documenting adverse, unplanned, or untoward events on an accident/incident form. Accident/incident forms are completed by staff who either witness an adverse event or were the first to respond. Accident and incident forms are reviewed by management and signed off when completed. The registered nurses undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>Policy and procedures comply with essential notification reporting, for example health and safety, human resources, and infection control. The GM is aware of situations in which the service would need to report and notify statutory authorities including, police attending the facility, unexpected deaths, sentinel events, notification of a pressure injury, infectious disease outbreaks, and changes in key clinical managers. Authorities have been notified of the recent appointment of the clinical nurse manager.</p>
Standard 1.2.7: Human Resource Management	PA Low	<p>Written policies and procedures in relation to human resource management are available. Current copies of annual practising certificates were reviewed for all staff and contractors that</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>require them to practice. The selection and approval of new staff is the responsibility of the GM and CNM. The GM will continue to monitor staffing selection as part of her contract staffing role. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities, and authority. These were reviewed on staff files along with employment agreements, reference checks and police vetting.</p> <p>Interviews with caregivers (CG) confirmed new CG's are paired with a senior CG for shifts or until they demonstrate competency on a number of tasks including personal cares for residents. Care givers confirmed their roles in supporting and buddying new staff. Completed orientations were sighted in staff files reviewed.</p> <p>Competency assessment questionnaires for relevant competencies required for specific positions, such as handwashing, wound management, medication management, moving and handling, restraint and assisting residents to shower were sighted in staff education files reviewed.</p> <p>There were five of the seven RNs that were interRAI competent.</p> <p>The organisation has a mandatory education and training programme with annual training days provided, however not all staff have attended the mandatory education and training requirements.</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>Staffing levels meet contractual requirements. The CNM, who is a RN is available during the weekdays and on call after hours and weekends. Registered nurse cover is provided 24 hours, 7 days a week and are supported by sufficient numbers of care givers.</p> <p>There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Rosters are completed by the CNM and overseen by the GM. Rosters sighted reflected that staffing levels meet resident acuity and bed occupancy. The roster did not evidence staff who have a current first aid certificate (refer to 1.2.7.4).</p> <p>Residents and families reported staff provide them with adequate care. Care staff reported there are adequate staff available and that they are able to get through their work.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current,</p>	<p>FA</p>	<p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of residents' records. Files, relevant to resident care, and support information could be accessed in a timely manner. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents</p>



<p>confidential, and accessible when required.</p>		<p>or members of the public.</p> <p>Residents' files are maintained securely. Electronic data is password protected and can only be accessed by designated staff. Archived material is also kept securely and easily retrievable.</p> <p>All components of the residents' records reviewed include the resident's unique identifier. The clinical records reviewed are integrated, including information such as medical notes, assessment information, and reports from other health professionals. Entries are legible, dated and signed by the care giver(CG), RN or other health professional, and include their designation. Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals (refer 1.3.3.3).</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The entry to service policy includes all the required aspects of the management of enquiries and entry. Woodfall lodge admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the residents, family/whānau of choice where appropriate, local communities, and referral agencies. Completed Needs Assessment and Service Coordination (NASC) authorisation forms for rest home and hospital level of care residents were sighted.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and signed on entry. The admission agreement clearly outlines services provided as part of the entry agreement. Relatives and residents interviewed confirmed that they received sufficient information regarding the services to be provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. All required documents such as resuscitation status, recent progress notes, care plan, behavioural monitoring, and medication charts are included in the discharge or transfer pack. Residents and their families are involved in all exits or discharges to and from the service and there was sufficient evidence in the resident's records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with</p>	<p>PA Moderate</p>	<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</p>

<p>current legislative requirements and safe practice guidelines.</p>		<p>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 NP. 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 registered nurse was observed administering medication following the eight rights of medication administration. Records of fridge and room temperature monitoring were sighted. Medications were stored safely and securely in the locked cupboards.</p> <p>An improvement is required relating to consistently completing six monthly controlled drug stock take and self-administration competencies.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>There is an approved food plan for the service which expires on 24 May 2022. Meal services are prepared on-site and served in the respective dining areas. The kitchen staff have current food handling certificates. Diets are modified as required and the cook 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 residents' weight was monitored regularly, and supplements were provided to residents with identified weight loss issues. Nutritional snacks are available for all residents if needed.</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; however, an improvement is required to ensure all damaged surfaces meet infection prevention and control standards (Refer 1.4.2.4). The residents and family/whanau interviewed 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>An improvement is required to ensure the menu is reviewed every two years in line with recognised nutritional guidelines appropriate to the consumer group.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the</p>	<p>FA</p>	<p>The clinical nurse manager reported that all people who are declined entry are recorded on the pre-inquiry form and when a person is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The person is referred to the referral agency to ensure that they will be admitted to the appropriate service provider.</p>

consumer and/or their family/whānau is managed by the organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Residents have their level of care identified through the needs assessment by the NASC agency. The initial assessments were completed within the required time frame on admission while care plans and interRAI were completed within three weeks according to policy. Some of the ongoing reviews completed did not meet time frames that safely met the needs of the residents or ARCC contract requirements (refer 1.3.3.3). Assessments and care plans included input from the residents, family/whānau, and other health team members as appropriate. The nursing staff utilises standardised risk assessment tools on admission. Residents and relatives interviewed expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans were resident focussed, integrated, and provided continuity of service delivery. The assessed information is used to generate long-term care plans and short-term care plans for acute needs. Goals were specific and measurable, and interventions were detailed to address the desired goals/outcomes identified during the assessment process.</p> <p>The residents and relatives interviewed confirmed care delivery and support are consistent with their expectations and plan of care. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as district nurses, physiotherapists, NASC team, dietitians, and NP.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>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 NP reported that communication was conducted in a transparent manner, 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 level of care provided and following the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	FA	<p>The planned activities are meaningful to the residents and their needs and abilities. Activities are conducted by the activities coordinator who has been in the role for three months. The activities are based on the golden carers programme and assessments reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments.</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>Residents' files sampled reflected their preferred activities and were evaluated regularly or as necessary.</p> <p>The activities coordinator develops a weekly activity planner which covers activities for the rest home, hospital and respite level of care residents. Residents' activities information was completed in consultation with the family during the admission process. Activities are varied and included pet therapy, baking, word games, bowls, men's shed, music, movies, one on one time, nail and hair care, calendar themed activities, arts, and craft, and van outings occur every three months. Weekends are reserved for family visits, movies, and colouring activities. Participation records are completed. Residents' meetings were conducted monthly, and progress notes were completed.</p> <p>The residents were observed participating in a variety of activities on the days of the audit. There are planned activities and community connections that are suitable for the residents. Regular outings were completed for all residents except under Covid-19 lockdowns. Residents and family/whānau interviewed reported overall satisfaction with the level and variety of activities provided.</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>Residents' long-term care plans, interRAI assessments, and activity plans were evaluated and updated when there were any changes. However, some interRAI assessments were not completed in a timely manner and activity care plans were not evaluated in conjunction with interRAI assessments (refer 1.3.3.3). Relatives, residents, and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short-term care plans were developed when needed and signed and closed out when the short-term problem has resolved.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The NP confirmed that processes are in place to ensure that all referrals are followed up accordingly. The resident and family were kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or NP. Referrals were made to the mental health team, dietitian, physiotherapists, district nurses, podiatry services, and palliative care team, respectively.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies and procedures in place for the management of waste and hazardous substances. The supplier of chemicals has conducted staff training and education in the use of the current systems. Safety data sheets were available and accessible for staff. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>Protective clothing and equipment appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff.</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>A current building warrant of fitness is displayed.</p> <p>There is a preventative maintenance programme in place to replace tired, worn and damaged surfaces. However, visual observations noted several environmental surfaces did not meet infection prevention and control standards. The maintenance staff member, who was present at audit reported the process for reactive maintenance to ensure timeliness of urgent repairs are conducted.</p> <p>Equipment is maintained to an adequate standard, documentation reviewed, and staff interviews confirmed this. The testing and tagging of equipment and calibration of biomedical equipment is current.</p> <p>The external areas are safely maintained and appropriate to the resident group and setting. Residents are protected from risks associated with being outside. The gardens are maintained by a resident and the maintenance personal.</p> <p>Staff interviews confirmed they have appropriate equipment to meet residents' needs. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>The facility has a van that is used for residents' outings, and this meets legislative requirements.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene</p>	<p>FA</p>	<p>Bedrooms throughout the facility have a handbasin. There are adequate numbers of communal toilets and bathrooms of an appropriate design for residents (refer to 1.4.2.4). Separate toilets are available for staff and visitors. Communal toilets and showers have a system that indicates if it they are vacant or occupied. Appropriate secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</p> <p>Hot water temperatures are monitored monthly. When there have been hot water temperatures</p>

requirements or receiving assistance with personal hygiene requirements.		above the recommended safe temperature, action is taken and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Residents' bedrooms are personalised to varying degrees. The bedrooms are single occupancy. 36 rooms have been approved as dual purpose and two rooms for rest home level care only. The bedrooms identified as dual purpose are large enough to allow staff and equipment to move around safely and provide personal space for residents.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is adequate access to lounges, dining areas and sitting areas/alcoves. Residents were observed moving freely within these areas. Residents confirmed there are alternative areas available to them if communal activities are being run in one of these areas and they do not wish to participate in them.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	<p>Cleaning and laundry policies and procedures are available. Laundry is completed on site. Interview with the housekeeping staff member described the management of laundry including the transportation, sorting, laundering and the return of clean laundry to residents. Residents' personal clothes, such as woollen clothes are washed separately.</p> <p>The housekeeping staff member described the cleaning processes and the use of chemicals for cleaning purposes. There are safe and secure storage areas for cleaning equipment and chemicals and staff have access to these areas as required. A sluice room is available for the disposal of soiled water/waste. Handwashing facilities are available throughout the facility with alcohol gels in various locations.</p> <p>Residents and family satisfaction surveys have not been collated for the June 2021 survey and there was no documented evidence of the 2020 survey to ascertain satisfaction with the laundry and cleaning services. (refer to 1.1.9.1 and 1.4.2.4). The effectiveness of the cleaning and laundry services is audited via the internal audit programme.</p>
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and	PA Low	Documented systems are in place for essential, emergency and security services. The fire evacuation scheme for the facility has been approved by the New Zealand Fire Services. The trial fire evacuations are conducted six monthly. The last fire evacuation drill was conducted in

<p>timely response during emergency and security situations.</p>		<p>June 2021. The staff training register evidences that not all staff have completed first aid training (refer 1.2.7.4).</p> <p>There is emergency lightening, gas for cooking, emergency water supply, blankets in case of emergency, in sufficient quality to the number of residents.</p> <p>The call bell system in place is used by the residents, and/or staff and family to summon assistance if required. The call bell availability to a level appropriate to the service setting requires review.</p> <p>Staff interviews confirmed security systems are in place and staff are aware of security processes. Staff are aware of which entrances are fire exits and those that require closing at night.</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 and safe ventilation. Residents and families confirmed the facility is maintained at a safe and comfortable temperature. Audit documents reviewed confirmed this.</p> <p>An area outside the building is available for residents who smoke.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Woodfall Lodge provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an appropriate infection prevention and control programme. The clinical nurse manager is the infection control coordinator (ICC) and has access to external specialist advice from the NP and DHB infection control specialists when required. A documented role description for the ICC including roles and responsibilities is in place.</p> <p>The infection control programme is reviewed annually. Staff is made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for residents, staff, and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. The staff interviewed demonstrated an understanding of the infection prevention and control programme and the use of personal protective equipment (PPE). There was a pandemic outbreak plan in place. The covid-19 outbreak management plan was in place and any latest information about Covid-19 is regularly updated.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the monthly staff and quality meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits, and investigations respectively.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The service has documented policies and procedures in place that reflect current best practices. Policies and procedures are accessible and available for staff at the nurses' station. These were last reviewed in December 2019. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique, and use of disposable aprons and gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Staff education on infection prevention and control is conducted by ICC and other specialist consultants. The ICC has not completed an infection prevention and control training in the last year to keep their knowledge current (Refer 1.2.7.2). The training education information pack is detailed and meets best practices and guidelines. The following education sessions have been provided; hand hygiene, IPC outbreak management, use of PPE, and food handling. External contact resources include NP, laboratories, and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance programme is defined and appropriate to the size and scope of the service. All residents' infections are recorded in the residents' files using the infection data collection form. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, quality, and management meetings. Evidence of completed infection control audits and reports were</p>



		<p>sighted.</p> <p>Staff interviewed confirmed that they are informed of infection rates as they occur. The NP is informed within the required time frames when a resident has an infection and appropriate antibiotics are prescribed for all diagnosed infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and guide the safe use of both restraints and enablers. Definitions of restraint and enablers are consistent with the standard. Residents confirmed that they were being supported in maintaining and promoting independence and safety. Records sampled confirmed that staff receive ongoing education on restraint/enablers and challenging behaviour. Restraint minimisation and safe management training is conducted. One resident was using a bed rail as a restraint and none were using an enabler on the days of the audit.</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 service providers and others.</p>	FA	<p>The clinical nurse manager reported that there is a restraint approval group, made up of the quality team members namely, NP, the clinical nurse manager, registered nurse, caregiver, and these are responsible for the approval for the use of restraints and the restraint processes. It was evident from the review of quality meeting minutes, residents' records, and interviews with the restraint coordinator that there are clear lines of accountability and that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/whānau/EPOA involvement in the decision-making was on record in each case reviewed. The use of restraint or an enabler is part of the plan of care.</p>
<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>Assessments for the use of restraint were documented and included all requirements of the Standard. The restraint coordinator undertakes the initial assessment with input from the resident's family/whānau/EPOA and NP. The restraint coordinator described the documented process. Families confirmed their involvement. The NP is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives, and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of the resident who was using a restraint.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraint is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members including the use of sensor mats and low beds. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are respected.</p> <p>A restraint register was maintained, updated every month, and reviewed at each integrated staff meeting. The register was reviewed and contained the resident currently using restraint and enough information to provide an auditable record.</p> <p>The staff has received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use. Staff were trained in restraint minimisation and managing challenging behaviour.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Regular reviews are conducted on the resident with restraint, and this was evident in the records sampled. The NP confirmed involvement in the restraint review process. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring, and any change required. Staff and family/whanau confirmed involvement in restraint use evaluations. The evaluation forms included the effectiveness of the restraint, and the risk management plans were documentation in the long-term care plans. Evaluation time frames are determined by the risk levels.</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>	<p>FA</p>	<p>The service has demonstrated monitoring and quality review on the use of restraint. Internal audits are conducted regarding restraint use. Policies and procedures are current. The care plan sampled identified the use of restraint and interventions in place. Three monthly restraint use reviews were conducted in a timely manner. Corrective actions regarding care plan documentation, completing of monitoring forms are conducted. The corrective actions are discussed at the quality and monthly staff meetings. Restraint updates are routinely included in the monthly staff and quality meetings. Meeting minutes confirmed discussions on restraint are being conducted and included a review of restraint use. Restraint usage is kept to an absolute minimum. Management and de-escalation technique was conducted on 19 May 2021.</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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>The facility has a newly employed activities person. The role description includes the responsibility of the monthly resident/family meetings and the development of the facility newsletter.</p> <p>A family member interviewed stated they no longer received the facility newsletter, which they looked forward to as it stated staff changes and happenings at the facility.</p> <p>The general manager (GM) stated emails had been sent from the facility regarding changes to levels around Covid-19 in line with information received from the Ministry of Health.</p>	<p>Family and resident interviews reported:</p> <p>(i) resident and family members meetings are inconsistently held. Meeting minutes evidenced only one meeting dated March 2021.</p> <p>(ii) The facility newsletter is no longer completed.</p> <p>(ii) The resident and relatives survey was completed 28th June 2021 and still requires collation and reporting. However, there is no documented evidence a survey was completed in 2020.</p>	<p>(i) Provide evidence that resident and family meetings are held regularly.</p> <p>(ii) A facility newsletter is completed.</p> <p>(iii) the resident and family survey is collated, analysed, and reported through to appropriate</p>

				personal.  90 days
<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>	PA Low	<p>The facility policy defines each registered nurse and the activities person is to have a current first aid certificate. Review of the staff files evidenced that not all registered nurses had completed the training including the CNM.</p> <p>The staff roster did not evidence staff who have a current first aid certificate. The risk rating has been reduced to low as all RNs without a current first aid certificate have been booked for certification on the 12th July 2021, following discussion at audit.</p> <p>The CNM is the infection prevention and control coordinator, however there is no documented evidence of education required for this role.</p>	<p>(i) Not all registered nurses have a current first aid certificate.'</p> <p>(ii) There is no documented evidence the CNM has received recent infection prevention and control (IPC) education.</p>	<p>(i) Provide evidence that all RNs have a current first aid certificate.</p> <p>(ii) Provide evidence the CNM has received recent training for the IPC coordinator's role.</p> 30 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	<p>The policy requires weekly and six monthly stock takes to be completed, during visual checks on the audit days, weekly controlled drugs stock takes were conducted, however six-monthly stock takes were not being consistently completed.</p>	<p>Six-monthly controlled drugs stock take was not consistently completed as per policy requirements.</p>	<p>Ensure six monthly controlled drugs stock take are completed to comply with policy requirements and current legislation.</p> 60 days

<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>There were two residents self-administering medication at the time of the audit, and one resident's self-administering competency was not completed in a timely manner. Medication was stored securely. There is a policy and procedure for self-administration of medication to guide staff.</p>	<p>Self-administration competency for one resident was not completed three monthly as per medication policy requirements, last reviewed 11 November 2020.</p>	<p>Complete self-administration competencies for residents who self-administers medicines in a timely manner</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 seasonal menu in place. The menu was reviewed by a dietitian in November 2018, and it has been overdue for seven months.</p>	<p>The four weekly seasonal menu, has not been approved by a dietitian since November 2018 as per previous dietitian report.</p>	<p>Provide evidence of current menu review by a registered dietitian.</p> <p>90 days</p>
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	<p>PA Moderate</p>	<p>The initial assessments, interRAI assessments, and initial care plans were completed within three weeks of admission and long-term care plans were reviewed every six months or when there was any change in the condition of a resident. Nine (9) interRAI reassessments reviews were not completed within the required timeframes with an overdue interval ranging from 27 to 52 days.</p> <p>A medical assessment on admission was undertaken in a timely manner and reviewed as a resident's condition changes, or monthly unless the resident's condition is documented as stable.</p>	<p>(i) There were nine (9) overdue interRAI assessments.</p> <p>(ii) Four (4) activity care plans sampled were not developed in conjunction with interRAI assessments.</p>	<p>(i) Ensure all interRAI assessments are completed within timeframes that safely meet the needs of the residents and ARCC contract requirements.</p> <p>(ii) Ensure activity care plans are developed</p>

				following outcomes from interRAI assessments.  90 days
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	<p>There is a documented maintenance programme and plan to replace old, worn, and damaged surfaces, such as the carpet. However, several physical environmental surfaces do not allow ease of cleaning to meet infection prevention and control standards.</p>	<p>(i) Chipped formica on the bench between the kitchen and dining area in the Makino wing.</p> <p>(ii) Refurbishment in the kitchen including installation of tiles in the wet areas has not been completed.</p> <p>(iii) Bathroom vinyl that is worn and not adhered to the floor or wall surfaces, in the Rimu wing.</p> <p>(iiii) Worn and stained carpet throughout the facility</p> <p>(iiii) internal doors in the Makino wing were noted to have significant damage on the outside coverings.</p>	<p>Ensure all physical environmental surfaces are presented in a condition that meets infection prevention and control standards.</p> <p>180 days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	PA Low	<p>The facility has two call bell systems. One for the Makino and Bowen wing and another for the Rimu wing. Each system requires a different cord for usage. One incident reported noted when the emergency bell was rung by a staff member it was not heard across the facility.</p>	<p>Each current resident has a call bell and cord that is functional. However, there are insufficient cords to ensure each of the facility resident room, dining areas and lounges has a functional call bell.</p> <p>Discussion with the GM in relation to the call bell system noted two older systems and the cords were not readily available, and this required juggling of residents' rooms</p>	<p>Ensure each resident area has a call bell and cord that is functional.</p> <p>90 days</p>

			to enable each resident to have a call bell that is accessible and within reach and available. Handheld bells are used if required.	
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## 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.

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End of the report.