

Jonwell Healthcare Limited - Wimbledon Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Jonwell Healthcare Limited

Premises audited: Wimbledon Rest Home

Services audited: Hospital services - Medical services; Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 6 December 2021 End date: 7 December 2021

Proposed changes to current services (if any): Change of ownership. The expected settlement date is 1 February 2022. Please note the service is also certified for hospital- geriatric and this is not included in the table above but should be.

Total beds occupied across all premises included in the audit on the first day of the audit: 35

Executive summary of the audit

Introduction

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

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

General overview of the audit

Wimbledon Villa is privately owned and provides rest home, dementia, and hospital level of care for up to 38 residents. On the day of the audit, there were 35 residents. A clinical nurse manager and business facility manager are responsible for the daily operation of the facility. They are supported by a clinical team leader and internal auditor, registered nurses, and care staff.

This provisional audit was conducted against the Health and Disability Services Standards and the services contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, the owner, prospective providers, and a general practitioner.

The audit established how well prepared the prospective providers are to provide a health and disability service. The prospective providers consist of two owners (husband and wife). The prospective providers understand the Health and Disability Standards and the Aged Residential Related Care Agreement. One of the prospective providers, who is an RN, is experienced in the aged care sector. The second owner has a non-clinical background.

The prospective owners provided a transition plan and that they will maintain all staff, equipment, policies, procedures, management systems, company structure to minimise any disruption. The expected settlement date is 1 February 2022. The DHB is aware of the pending change of ownership.

Two shortfalls identified at this audit relate to the training, and safe processing of laundry services.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights is made available to residents. Staff demonstrated an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents.

The service has a culture of open disclosure. Families are regularly updated of the resident's condition, including any acute changes or incidents. Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Staff provided residents and families with the information they need to make an informed choice and to give consent. A complaint register is in place and complaints are managed by the business facility manager.

Organisational management

Quality and risk management programmes are embedded into practice. Data is collected, analysed, and discussed with staff. Quality improvement plans are developed and implemented when service shortfalls are identified. Quality improvement data is communicated to staff and other stakeholders as appropriate. Adverse events are documented, and follow-ups are completed. Various meetings are held. The hazard register evidenced review and updating of risks and the addition of new risks.

Policies and procedures on human resources management are in place and processes are followed. In-service education has been provided and staff performance is monitored.

A documented rationale for determining staffing levels and skill mixes is in place. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Residents' information was accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete interRAI assessments, and care planning. Care plans demonstrate service integration. Care plans were updated for changes in health status.

The activity programmes meet the ability and needs of residents. There is provision for group and individual one-on-one activities. There is a separate programme for the rest home/hospital residents and the dementia unit. There were 24-hour activity plans for residents in the dementia care unit that were personalised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly or more frequently as required.

A dietitian reviews the menu. Individual and special dietary needs are accommodated. Nutritional snacks are available 24-hours for residents in the dementia unit. Residents interviewed responded favourably to the food provided.

Safe and appropriate environment

Wimbledon Villa has a current building warrant of fitness. Reactive and preventative maintenance occurs. Medical equipment and electrical appliances have been calibrated. All bedrooms are single occupancy. There is sufficient space to allow the movement of residents around the facility using mobility aids including for residents at hospital level care in any of the dual-purpose rooms. There are lounge, low stimulus areas and dining areas throughout the facility.

There is a designated laundry at the site and a separate housekeeping room which includes the safe storage of cleaning and laundry chemicals. There is a documented process for waste management. External garden areas are available with suitable pathways, seating and shade provided. Appropriate training, information, and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit, there were no residents with restraint and no residents using enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours.

Infection prevention and control

The infection control programme is appropriate for the size and complexity of the service. There are appropriate policies and guidelines for the scope of the programme. The infection control coordinator is the clinical nurse manager who is responsible for providing education and training for staff. Infection control training is provided on orientation and ongoing. Surveillance of infections occurs, and this is communicated to staff. The service maintains PPE stocks for Covid-19 pandemic use.

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	43	0	2	0	0	0
Criteria	0	91	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Staff receive training about the Code during their induction to the service. This training continues through in-service education. Interviews with 10 staff (four healthcare assistants (HCAs) who work across all three shifts, two registered nurses (RNs), one cook, one housekeeper, a diversional therapist and one clinical team leader) reflected their understanding of the key principles of the Code. They can apply this knowledge to their job role and responsibilities. Three relatives (hospital resident relatives) and seven residents (five hospital and two rest home) interviewed stated that resident rights were respected well and reflected a caring and supportive environment.</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</p>	<p>FA</p>	<p>The service has a policy in place for informed consent and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Written consents are included in the admission agreements, which are signed on admission to the service</p>

<p>choices and give informed consent.</p>		<p>(one of six agreements viewed was not signed as a court appointed welfare guardian was yet to be appointed) and includes the use of social media. The advanced directives/resuscitation policy was implemented in all the resident files reviewed. Informed consent processes are discussed with residents and families on admission. The residents in Courtyard Villa (dementia) have activated enduring powers of attorney (EPOA) in place.</p> <p>Interviews with HCAs and residents identified that consents are sought in the delivery of personal cares. Discussion with relatives identified that the service actively involves them in decisions that affect their relative's lives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Advocacy information is available to residents in the service entrance, and in the information pack which is provided to residents or family/whānau prior to the time of entry to the service. Interviews with residents and family/whānau confirmed they were aware of their right to access advocacy and support person. The resident files reviewed included information on the resident's chosen networks. Staff training in the code of rights and advocacy has been provided. Staff interviewed were knowledgeable around how to access advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are encouraged to maintain links with their family/whānau and the community, however restrictions have been applied due to the Covid-19 pandemic. In general, residents and family/whānau members interviewed stated they felt comfortable about the way it was managed and were kept well informed. Two family/whānau members interviewed were not happy with the restrictions. They stated that they want to continue with daily visiting by multiple family/whānau members, now they are restricted to three times a week because of the booking system. One relative stated that she was visiting daily when the resident was unwell and able to continue daily visiting until he improved. Interview with the clinical nurse manager confirmed flexibility around visiting hours for new admission to service, dementia level care</p>

		and palliative care residents.
<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. Information on the complaint process is provided to residents and families/whānau on admission and those interviewed knew how to complain if they so wished.</p> <p>A record of all complaints received is maintained by the business facility manager using an electronic complaints' register. Discussions with residents and family/whānau confirmed they were provided with information on complaints and complaints forms. To date, three complaints have been received in 2021. All complaints reviewed had documented evidence of follow up, feedback to the complainant or outcome resolution.</p> <p>One of the complaints documented was made to the Health and Disability Commissioner (HDC) but this was subsequently withdrawn within days. There have not been any other complaints to external providers since the last audit.</p> <p>The business facility manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The clinical nurse manager or an RN discusses aspects of the Code with family/whānau on admission. Further discussions relating to the Code are held during the family/whānau meetings. Relatives interviewed confirmed that residents' rights are being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe on interview how they</p>

<p>manner that has regard for their dignity, privacy, and independence.</p>		<p>manage to maintain privacy and respect of personal property. Residents and family/whānau members interviewed stated staff were very respectful and maintained resident dignity at all times. Staff receive training around privacy and dignity and elder abuse and neglect is part of the training programme.</p> <p>Resident preferences are identified during the admission and care planning process, and this includes family/whānau involvement. Interviews with HCAs described how choice is incorporated into resident cares.</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 is committed to ensuring that the individual interests, customs, beliefs, and cultural and ethnic backgrounds of Māori are valued and fostered within the service. Staff encourage active participation and input of the family/whānau in the day-to-day care of the resident. Cultural preferences and support were identified in the cultural needs section of the long-term care plan.</p> <p>At the time of the audit there were six residents (one dementia level care, two hospital and three rest home level care) who identified as Māori living at the facility. A Māori health plan was being implemented. Māori consultation is available through the local iwi, Te Runanga O Raukawa. There are two staff who speak fluent te reo Māori and interview with the staff members confirmed that they both speak te reo Māori with residents in their one-to-one interactions. One Māori resident interviewed confirmed that their cultural needs are met. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic on training days. The HCAs interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Wimbledon Villa recognises the cultural diversity of its residents, families, and staff. Policies and procedures reflect diverse beliefs and cultures. The residents' personal needs and values were identified on admission and this information was gathered from previous interRAI assessments and interviews with residents, family/whānau and/or the</p>

		<p>enduring power of attorney (EPOA). All care plans reviewed included the resident's social, spiritual, and cultural needs. HCAs were able to give examples of how they meet the individual needs of each resident they care for. Relatives and residents interviewed confirmed that staff take into account their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The service has organisation-wide policies and procedures to protect consumers from any form of discrimination, coercion, harassment, or exploitation. Relevant policies and procedures have been implemented. Staff orientation and in-service education provide ongoing awareness around prevention of any discrimination, coercion, and harassment.</p> <p>The business facility manager, clinical nurse manager and HCAs interviewed, demonstrated a clear understanding of professional boundaries. Documented job descriptions describe the functions and limitations of each position. Professional boundaries are defined in job descriptions. Staff files reviewed had a signed document around the organisation's code of conduct.</p> <p>Resident and family/whānau members reported no concerns around any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures, and a staff training programme which covers all aspects of service delivery. Internal auditing programmes are implemented. Action plans focusing on adverse trends are documented including wounds, infections and falls with injury all of which are showing reducing trends.</p> <p>The policies and procedures are developed by a contracted nursing consultant which is linked with their digital resident management system. Updated documents are noted including a Covid-19 pandemic plan.</p> <p>RNs are achieving 20 hours professional development a year through Ko Awatea (DHB learning platform) and other external training as well</p>

		<p>as internal in-service programme. Wimbledon Villa is part of the local hospice SEQUAL (Supportive Education and Quality Palliative Care) programme. The clinical nurse manager reported monthly meetings with the local hospice clinical nurse specialist to review residents with a view to identifying and improving end of life care issues such as symptom management. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families/whānau have a right to know what has happened to them and to be fully informed at all times. The care staff interviewed understood about open disclosure and providing appropriate information when required. Relatives interviewed stated they were welcomed on entry of their family member and were given time and explanation about the services and procedures.</p> <p>Accident/incidents, complaints procedures and the policy alert staff to their responsibility to notify family/whānau of any accident/incident and ensure full and frank open disclosure occurs. Twelve incidents/accidents forms selected for review indicated that family/whānau were informed. Families/whānau interviewed confirmed they are notified of any changes in their family member's health status and/or if an adverse event had occurred.</p> <p>Relative interviews confirmed that communication around Covid-19 visiting protocols and updates occur.</p> <p>Staff know how to access interpreter services through the district health board, although reported this was rarely required because all current residents are able to speak English.</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</p>	FA	<p>Wimbledon Villa is privately owned and run by the facility business manager. There is a business marketing plan 2020-2021 that includes the business values, objectives, and goals.</p>

<p>consumers.</p>	<p>The service provides rest home, hospital, and dementia level of care for up to 38 residents. There is an 18-bed dual-purpose (rest home/hospital) wing and a 20-bed secure dementia care wing. On the day of the audit, there were 35 residents in total, eight residents at rest home level, nine residents at hospital level and 18 dementia level residents (including one resident under the age of 65 in the dementia unit on the 'like in age and interest' contract). All other residents were under an Age-Related Residential Care (ARRC) contract. All rest home and hospital rooms had dual service capacity.</p> <p>The business facility manager (non-clinical) has been in the role for eleven years. The business facility manager is supported by a clinical nurse manager who has 4 years aged care experience and has recently been appointed to the role. A clinical team leader oversees the dementia unit and has two years' experience in aged care. The management team are supported by an internal auditor employed for 14 hours per month who oversees the internal auditing programme.</p> <p>The clinical nurse manager and business facility manager have attended at least eight hours of professional development relevant to their role.</p> <p>The prospective providers consist of two owners (husband and wife). One of the prospective providers, who is an RN, is experienced in the aged care sector and is currently employed by an aged care facility in a clinical manager role. She has a seven-year NZ work experience as a RN in facilities with rest home, dementia, and hospital level of care. She has postgraduate diploma in advanced nursing. The second prospective provider has a non-clinical background.</p> <p>A transition plan reviewed, and interview with the prospective providers and the business facility manager evidenced that the current owner is committed to providing a comprehensive handover during the transition. The prospective providers reported that the expected settlement date is 1 February 2022. They reported that they will maintain all staff, equipment, policies, procedures, management systems, company structure to minimise any disruption. They will be moving to Feilding/Palmerston North prior to settlement so they will be on site on a regular basis to get familiar with residents, families/whānau, staff, managers, and the facility while overseeing financial and governance</p>
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		<p>support when needed.</p> <p>The DHB is aware of the pending change of ownership.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical nurse manager covers the facility during the temporary absence of the business facility manager, the clinical team leader covers the clinical nurse managers leave. The prospective providers advised that they would continue operating under the same arrangement.</p> <p>The prospective providers understood the needs of the different certified service types and understands the Aged Residential Related Care (ARRC) agreement.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a documented quality and risk management system. The service contracts an aged care consultant to develop and review policies and procedures which are available on the intranet. Staff are informed of any policy updates. The prospective providers advised that they would continue with the current system.</p> <p>The internal auditor (non-clinical) coordinates and completes non-clinical audits. Quality improvement data included adverse event forms, internal audits, meeting minutes, satisfaction surveys, infection rates and health and safety. Corrective action plans are consistently completed. Clinical audits were completed by the clinical nurse manager.</p> <p>Meetings were generally being held as planned. Meetings included team meetings, RN meetings, management meetings, night staff meetings. health and safety with infection control (IC) discussed in these meetings. The exception was a change in frequency of the meetings since September due to Covid-19 restrictions and pressure on staffing. Meeting minutes did evidence reporting of completed internal audits, quality data, infection control and health and safety and complaints. Staff interviews confirmed that they were kept up to date about quality data and the Covid-19 pandemic plan and ongoing training occurs around infection prevention and control.</p>

		<p>Health and safety policies are available. Actual and potential risks are identified associated with all activities at the facility. The hazard register identifies hazards and evidenced the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The clinical team leader is the health and safety representative, however training around this has not been completed (link 1.2.7.3). The hazard register was last reviewed in July 2021.</p> <p>Annual resident/relative satisfaction surveys are completed with results communicated to residents and relatives. Seven participants completed the consumer survey in September 2021 and overall satisfaction was 84%.</p> <p>The prospective providers advised the policies and procedures currently being implemented will continue to be implemented and the quality and risk management plan will remain the same.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Twelve accident/incident forms (four from dementia unit, six from hospital and two from rest home) were reviewed for October – November 2021. Staff are documenting adverse, unplanned, or untoward events on an accident/incident form including neurological observation and falls risk assessments following accidents/incidents as appropriate. The clinical nurse manager and RNs are responsible for completing follow-ups. Data collected on the electronic incident and accident system is linked to the quality management system. Monthly trends and analysis were completed and reported back to the staff. Corrective actions are implemented where required.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families/whānau following adverse events involving the resident, or any change in the resident's condition. Families/whānau confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Discussions with the clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three Section 31 notifications in 2021. These were: one related to pressure injury, one to RN</p>

		shortage, and one reporting a delay in obtaining a Building Warrant of Fitness.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies to support recruitment practices. Seven staff files reviewed, including one clinical manager, one RN, one DT, one cook and three HCAs evidenced employment contracts, police vetting, references, and job descriptions. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period and annually thereafter.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Staff training exceeds well over 8 hours a year. The education programme covers the mandatory requirements at least two-yearly. Medicine management, infection control and challenging behaviour education is provided annually. Staff who are unable to complete internal training undertake written competency assessments. Individual education records are maintained. Training around health and safety that relates to the Health and Safety at Work Act 2016 has not been completed by staff.</p> <p>There are four interRAI trained RNs (including the clinical nurse manager). Of the 16 HCAs working in the dementia unit, six have completed the required dementia unit standards; ten are enrolled noting that of the ten, six HCAs had not enrolled prior to this within 18 months of employment.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Wimbledon Villa adjusts staffing levels to meet the changing needs of residents. There is a safe staffing policy and procedure that describes staffing requirements. The business facility manager works three days a week, and clinical nurse manager works full-time, Tuesday to Saturday and is available on call for any emergency issues. The</p>

		<p>clinical nurse manager and clinical team leader share the on-call for clinical matters.</p> <p>There is an RN on duty 24 hours in the rest home/hospital – Rose Wing. The clinical team leader is based in the dementia care wing – Courtyard Villa, five days a week. The hospital RN oversees the dementia wing on afternoons and nights. On weekends, either an RN or medication competent HCA supports the dementia wing.</p> <p>In the dementia unit (18 residents) there are two HCAs on the morning shift, three HCAs (one from 4 pm to 8 pm) on the afternoon shift and two HCAs on the night shift.</p> <p>In the rest home/hospital (8 rest home, 9 hospital) there are two HCAs on morning, two HCAs on afternoon shift and one HCA on night shift.</p> <p>Staff interviewed stated there were enough staff on duty and staff sickness/vacant shifts are covered. RNs and the clinical team leader support residents with high acuity. Relative and residents stated there were adequate staff on duty.</p> <p>The service reported a section 31 notification for RN shortages; however, they currently have 24hour RN cover.</p> <p>Laundry services (personal laundry) are provided by HCAs on a 24-hour timeframe, and housekeeping staff support delivery of laundry after completion of their duties.</p> <p>The prospective providers understood the required skill mix to ensure hospital, rest home and dementia residents needs are met.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Resident records are electronically maintained, and password protected. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</p> <p>Former resident's archived records are held securely on site (these were prior to use of the electronic system) and are readily retrievable</p>

		using a cataloguing system.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack with information around admission processes and entry to the service. This includes information on the dementia care secure wing. All residents are screened prior to entry by the business and clinical manager, to ensure they meet rest home, hospital, or dementia level care. Six files sampled (two hospital, one rest home and three dementia level care) evidenced processes are being followed and admission agreements signed with exception of one which was awaiting the appointment of a welfare guardian. Exclusions from the service and special charges are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The RNs interviewed described the nursing requirements as per the policy for discharge and transfers. The 'pink transfer envelope' is used, and includes a completed transfer form, the advanced directive and resuscitation status are included along with the medication chart and any other relevant information.</p> <p>Transfer to another facility or home following respite is planned and the relatives are well informed to ensure a smooth transition.</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>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised blister packs for regular and 'as required' (PRN) medications. Medication reconciliation is completed by an RN on delivery of medication and any errors are fed back to pharmacy. All medications were securely and appropriately stored in both areas on the day of audit. All RNs and HCAs who administer medication had been assessed for competency for medications on an annual basis. RNs have completed syringe driver training.</p> <p>The service uses an electronic medication management system. Twelve electronic medication charts were reviewed (two rest home, four</p>

		<p>hospital, and six dementia). The medication charts reviewed were clearly documented and signing sheets correct. The medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly.</p> <p>Staff were observed to be safely administering medications. Registered nurses and HCAs interviewed, could describe their role in regard to medicine administration. Standing orders are not used. There were no self-medicating residents at the time of audit.</p> <p>The medication fridge temperatures are recorded weekly, and these were within acceptable ranges. The temperature of the medication room is monitored and there were heat pumps in the treatment rooms for cooling and temperature control. Temperatures were within acceptable range as per policy.</p> <p>There is a signed agreement with the pharmacy.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The kitchen is located in the Courtyard Wing. All meals are cooked on site for the facility. The main cook working in the kitchen has food safety certificates (NZQA) and the 2nd cook who works weekends and part time some weekdays is undertaking training. A current food control plan is in place (expires February 2022). Food is served from the kitchen to the adjacent Courtyard dining area and plated in the kitchen and transported in hot boxes to the Rose wing.</p> <p>A nutritional assessment is completed by an RN as part of the assessment process, and this includes likes and dislikes. Nutritional profiles were evident for kitchen staff to access. This includes consideration of any dietary needs (including cultural needs). This was reviewed six-monthly as part of the care plan review or sooner if required. The menu is a four-weekly seasonal menu. The menu was designed and reviewed in April 2021 by a registered dietitian. There was evidence of residents receiving supplements.</p> <p>Fridges and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridges was covered and dated. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Special or modified diets are</p>

		catered for (sighted). There is evidence that there are additional nutritious snacks available over 24-hours.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reasons for declining service entry to prospective residents should this occur and communicates this to prospective residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred to the referring agency if entry were declined.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Files reviewed across all three service levels identified that risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation. Additional assessments for management of behaviour, depression assessment and chest infection risk were appropriately completed according to need. All six resident files reviewed contained long-term care plans and interRAI assessments. For the resident files reviewed, the outcomes from assessments and risk assessments were reflected into care plans.
<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>The long-term care plans reviewed included nursing diagnosis, actual or potential deficits, outlined objectives of care, goals and details of implementation. Resident care plans sampled were resident-centred and support needs were documented in detail. The three dementia resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. Residents and relatives interviewed, and resident files sampled confirmed that resident/relative/whānau were involved in the development/evaluation of care plans unless the resident wished otherwise. Relatives interviewed confirmed care delivery and support by staff was consistent with their expectations.</p> <p>Short-term care plans reviewed had been evaluated at regular intervals and either resolved or added to the long-term care plans.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the RN initiates a review by the GP. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met.</p> <p>Wound assessments, treatment and evaluations were in place for all eight current wounds (six skin tears, one chronic would and one moisture wound) across the facility (one resident had three skin tears and another two). There were four pressure injuries on the day of the audit (one resident with three had a significant contributing medical condition). The GP was notified of all wounds, and the wound care specialist had been involved with a chronic wound. Adequate dressing supplies were sighted in the treatment rooms. All RNs had undertaken wound assessment and management education through the district health board.</p> <p>Contenance products are available and resident files includes urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed.</p> <p>All weight is monitored at least monthly. Weight loss is discussed at RN clinical meetings and dietitian input requested as appropriate.</p> <p>The nurse practitioner for mental health of the older person and psychiatrist were involved with residents in the Courtyard Villa when required.</p> <p>Monitoring forms in place included (but were not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels and behaviour charts.</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>There is one diversional therapist employed at Wimbledon Villa, who along with a long-time volunteer who comes four days a week, provide activities over five days a week, with the HCAs providing activities over the weekend. The programmes (one for the rest home and hospital wing and one for the dementia wing are planned monthly and residents/family receive a copy with the bi-monthly newsletter.</p>

		<p>Activities for the month are displayed on noticeboards with the activities for the day in large print.</p> <p>A diversional assessment is undertaken for each resident with a plan put in place for each. The resident/family/whānau as appropriate, are involved in the development of the activity plan. Participation records are maintained with an evaluation recorded monthly in the residents' notes and a full review six monthly. The diversional therapist discusses the programme at the residents' meetings and one-on-one with residents to gain feedback. Relatives can feedback on the programme through the relative meetings (about to restart) and satisfaction surveys.</p> <p>Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities (these are usually once or twice weekly but during Covid have been restricted). The service has a van for community outings and a mobility van is also hired weekly for outings. Entertainers come three times a week and church services are held at the home.</p> <p>In the dementia unit the diversional therapist leads the activities. Residents were sighted engaging with staff in a variety of activities during the audit. HCAs were involved in the activities over a 24-hour period and have individual activities that can be carried out with residents on a one-on-one basis. HCAs were observed at various times throughout the day diverting residents from behaviours. Music therapy is available as a form of distraction.</p> <p>Residents and relatives interviewed, stated satisfaction with 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>Care plans reviewed had been evaluated by RNs at least six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans reviewed for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the clinical nurse manager, RN, HCAs, diversional therapist, and the clinical team leader. The relative/NOK are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical</p>

		practitioner. The relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits and were updated of all changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and/or their family/whānau are involved as appropriate when referral to another service occurs.</p> <p>Discussions with registered nurses identified that the service has ready access to nursing specialists such as wound, continence, palliative care, support of the older persons psychiatric team and diabetes nurse specialist. The physiotherapist is available as needed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Staff interviewed were aware of practices outlined in relevant policy. Safety datasheets are available to staff. Chemical bottles sighted have correct manufacturer labels and chemicals are stored safely throughout the facility. Gloves, aprons, and face shields are available, and staff were observed wearing personal protective clothing while carrying out their duties.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness, which expires on 8 July 2022.</p> <p>Wimbledon Villa has two wings. Courtyard Villa (dementia) has 20 single occupancy rooms. The Rose (rest home and hospital) wing has 18 single occupancy dual purpose rooms, eight of which have ensuites. There are paved looping walkways in the courtyard area of the Courtyard wing. There are well maintained raised flower beds, water features and handrails. Ten of the resident rooms have external access to the internal courtyard. The secure garden at the front of the facility is based on garden plants from the resident's era that they grew up with. Ramp access and pathways lead residents through the gardens with no</p>

		<p>dead ends. There are areas of shade available in the grounds.</p> <p>There is a large lounge in the Courtyard wing, a separate dining room and a smaller quiet lounge.</p> <p>The Rose wing has a separate small lounge and large dining area which is also used for activities. Residents were observed to move to the larger lounge area in the dementia unit when an entertainer visited. External areas were also well maintained and provide seating and shade and identified outside smoking areas. All communal areas were accessible to residents using mobility aids and the use of transferring equipment.</p> <p>The HCAs and RNs (interviewed) stated they have all the equipment required to provide the care documented in the care plans. The following equipment is available: electric beds, air alternating mattress, pressure relieving rings and boots, sensor mats, standing and lifting hoists, mobility aids and platform scales.</p> <p>The building holds a current warrant of fitness, which expires on 8 July 2022. Reactive and preventative maintenance occurs. Electrical equipment has been tested and tagged. Medical equipment has been calibrated by an authorised technician. Hot water and air temperatures are taken weekly in resident areas and were within the acceptable range. There is a designated maintenance person who works 21 hours per week and is available as needed.</p> <p>There is a reactive maintenance issue related to replacement of partial roof space. This is financially approved by the current owner and waiting the contractor to obtain roofing products. Completion of this work was delayed due to Covid-19 restrictions. The management team advised that this work is in progress.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are communal toilets in both wings including wet area shower rooms. There were shared facilities available within close proximity for the rooms without ensuite facilities. The communal facilities are close enough to meet the needs of the residents. There are eight ensuites in the Rose Wing and six in the Courtyard Wing. Fixtures, fittings and floor and wall surfaces are made of accepted materials for meeting</p>

		hygiene and infection control practices. The communal toilets and showers are identifiable. There are engaged/vacant signs on the doors. There are appropriately placed handrails in the bathrooms and toilets in the ensembles and communal areas.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. All resident beds are either electric hospital hi/low beds or manual beds, where height can be adjusted to suit resident need. Residents are encouraged to personalise their bedrooms. Staff and residents interviewed confirmed the bedrooms are large enough for mobility and manual handling equipment.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The Rose wing has a kitchenette area where the meals are served from one end of the designated dining area. There is a lounge area separate from the dining area for residents to enjoy television or group activities.</p> <p>Courtyard Villa has separate lounge and dining areas with direct access to the kitchen for the serving of meals. A separate small quiet lounge area is just off the dining area.</p> <p>Furniture is arranged to allow residents to freely mobilise between the different areas of each wing and to the outside garden areas. In both wings, the lounges are accessible and accommodate the equipment required for the residents.</p> <p>There are cameras in areas away from the main lounges connected to surveillance monitors for resident safety.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	PA Low	<p>The facility is cleaned by dedicated housekeeping staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>Personal laundry and towels are laundered on site by staff (HCAs and</p>

		housekeeping staff). Residents and relatives interviewed were satisfied with the laundry service. The bed linen is laundered off site. On the day of the audit there was a good supply of clean linen in the linen cupboards. There was a lack of separation of clean and dirty laundry.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation drills occur. The facility has emergency lighting, two diesel generators, 1600 litres of stored water and food for at least three days with a gas BBQ for alternative cooking, which can be used in the event of an emergency. Civil defence and first aid supplies are readily accessible and checked regularly. The staff interviewed could describe the emergency management plan and how to implement this. Emergency training is provided six-monthly in combination with the fire drill (November 2021 last drill). There is a qualified first aid trained staff member on each shift.</p> <p>There are call bells in the residents' rooms, toilets/shower rooms and communal lounge/dining room areas. Call bell audits are conducted monthly.</p> <p>There are double keypad secure gates into the secure dementia unit. There is free entry/exit into the rest home/hospital wing. The internal adjoining door between the rest home/hospital and dementia wing is secure by keypad. There are security cameras placed in public areas.</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>	FA	<p>All rooms have external windows that open, allowing plenty of natural sunlight. Communal areas and resident rooms are appropriately heated by heat pumps or ceiling heaters. The temperature can be individually adjusted in the resident bedrooms. Residents and relatives interviewed stated the environment was warm and comfortable. Air temperatures are checked and recorded on a monthly basis.</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>Wimbledon Villa has an established infection control (IC) programme; its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The clinical nurse manager is the designated (IC) coordinator. Infection control and prevention is an integral part of the quality management system. Audits have been conducted and include hand hygiene and IC practices. Education is provided for all new staff on orientation. There is ongoing training around infection prevention, Covid-19 precautions, and appropriate PPE use.</p> <p>Visitors are asked not to visit the facility if unwell. There are hand sanitisers placed throughout the facility. Residents and staff are offered the influenza and Covid-19 vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The clinical nurse manager is the designated IC coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC team comprising all staff and have good external support from the infection control nurse specialist at the DHB, aged care consultant, local laboratory, GP, and public health authorities. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>IC documents include a range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. There are policies around Covid-19 and outbreak management. Policies and procedures are up-to-date, and staff are notified of any reviews/updates at staff meetings.</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>	<p>FA</p>	<p>The IC coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions. Staff have undertaken formal infection control training along with training at staff handovers.</p>

		<p>Infection control training has occurred multiple times in 2021, this included Covid-19, hand washing, and PPE use training.</p> <p>The IC coordinator has completed online training to enhance her skills and knowledge. She has access to up-to-date information around infection prevention and control.</p> <p>On entry to service, Covid-19 health screening occurs, and visitor details are recorded. Covid-19 passports are checked on entry to the service for all visitors. PPE and antibacterial gels are available, and staff and visitors are encouraged to use these as appropriate. Staff interviews confirmed ongoing training around hand washing, Covid-19, and infection prevention and control. Staff interviewed were knowledgeable around these subjects.</p> <p>PPE and emergency infection control stock are sighted, this was stored appropriately in quantities appropriate for the size and scope of the service. There were 1000 surgical masks, 150 N95 masks, 20 boxes of aprons, 10 cartons of isolation gowns, 60 face shields, 40 googles, 10 cartons of hand sanitisers and 10 cartons of gloves.</p> <p>The current Covid-19 plan is updated by the external contractor and staff were familiar with this plan.</p> <p>Education with residents is generally on a one-to-one basis. Residents' interviews confirmed that they were reminded about handwashing, remaining in their rooms following respiratory symptoms and if they feel unwell, Covid-19 restrictions and limitations on visitors.</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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information monthly and enters data into the electronic system. The monthly analysis and graphs are attached to the team meeting minutes for staff information. Surveillance data are used to determine infection control activities and education needs in the facility.</p> <p>Definitions of infections in place are appropriate to the complexity of service provided. Systems in place are appropriate to the size and complexity of the facility.</p>

		There have been no outbreaks in the past two years.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. The service has no residents on restraint or with enablers. Alternative strategies and effective falls management strategies have ensured the facility has remained restraint free for a period of over three years. Staff receive training around restraint minimisation (May 2021) and de-escalation was undertaken by DHB personnel in February 2021. The clinical nurse manager oversees restraint minimisation for the service and an audit is undertaken annually.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>The annual education plan has mostly been completed to date. Training around health and safety that relates to the Health and Safety at Work Act 2016 has not been completed by staff.</p> <p>The education programme covers the mandatory requirements at least two-yearly. There are 16 HCAs who work in the dementia unit. Six have completed the required training in dementia. Ten are enrolled and of the 10, six have been employed in the service for longer than 18 months.</p>	<p>a) Not all staff working in the dementia unit have completed required dementia specific unit standards within the required timeframe (there are six HCAs currently undertaking dementia specific training who have been employed by the service over 18 months).</p> <p>b) Staff have not completed training around health and safety in relation to the change in legislation in 2016.</p>	<p>a) Ensure that HCAs who works at the dementia unit have completed the required dementia unit standards within 18 months of employment.</p> <p>b) Ensure that at staff complete training around health and safety as per schedule.</p> <p>180 days</p>
<p>Criterion 1.4.6.3</p> <p>Service providers have access to designated areas</p>	PA Low	<p>There is a separate sluice room where linen awaiting transfer to the laundromat twice weekly is stored. There is also a small laundry which contains a washer,</p>	<p>On day of audit the separation of clean and dirty laundry in the laundry was seen to be compromised. Personal linen hanging to dry was</p>	<p>Ensure a dirty to clean flow is maintained in the laundry.</p>

<p>for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>		<p>dryer, and tub. Space was minimal to facilitate an appropriate dirty to clean flow, however staff could describe how this is managed.</p>	<p>immediately over and in places touching the dirty linen (awaiting laundering) underneath.</p>	<p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.