

Heritage Lifecare Limited - George Manning Lifecare

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	George Manning Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 December 2021 End date: 15 December 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	82

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

George Manning Lifecare and Village provides rest home, hospital and residential disability service for younger people with a lifelong disability for up to 88 residents.

This certification audit was conducted in conjunction with a pilot audit of Nga Paerewa Health and Disability Services Standard NZS 8134:2021. The audit included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a general practitioner.

Strengths of the service included using data to improve service delivery, and a well-maintained environment.

Improvements are required in relation to:

- ensuring all policies and procedures are current, develop an employment policy
- interRAI assessments
- activities for under 65 year olds
- locked storage for residents who self-administer medication
- ensuring the hot water temperature is safe

- laundering of hoist equipment
- the policy for laundry services
- conducting a quality review of all restraint practices.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code), and these are respected. Personal privacy, gender, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreting services if required. Additional communication devices such as picture cards/word charts have been used to provide assistance to younger people with lifelong disabilities. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident’s needs. Links are also in place through external organisations that support services to younger people with lifelong disabilities.

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

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The governing body assumes accountability for delivering a high-quality service. This includes honouring Te Tiriti o Waitangi and reducing barriers to improve outcomes for Māori and people with disabilities.

Planning ensures the purpose, values, direction, scope and goals for the organisation are defined. Performance is monitored and reviewed at planned intervals.

The quality and risk management systems are focused on improving service delivery and care. Residents and families provide regular feedback and staff are involved in quality activities. An integrated approach includes collection and analysis of quality improvement data, identifies trends, and leads to improvements. Actual and potential risks are identified and mitigated.

Adverse events are documented with corrective actions implemented. The service complies with statutory and regulatory reporting obligations.

Staffing levels and skill mix meet the clinical needs of residents. Staff are appointed, orientated, and managed using current good practice. A systematic approach to identify and deliver ongoing learning supports safe equitable service delivery.

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

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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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. The young people with disability do not have an activity programme.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Waste and hazardous substances are well managed.

There was a current building warrant of fitness. Electrical equipment has been tested as required.

External areas are accessible, safe and provide shade and seating, and meet the needs of people with disabilities.

There are safe and effective laundry services. The facility meets the needs of residents and was clean and well maintained.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills.

Residents reported a timely staff response to call bells. Staff, residents and whānau understood emergency and security arrangements.

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.		Some standards applicable to this service partially attained and of low risk.
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The service aims for a restraint free environment. This is supported by the governing body and policies and procedures. One resident was using restraint at the time of audit, and one was using an enabler.

A comprehensive assessment, approval and monitoring process, with regular reviews occurs for any restraint used.

Staff demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques and alternative interventions.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed from district health board and public health unit when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	44	0	3	3	0	0
Criteria	0	94	0	3	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>George Manning Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code) but not all policies are current (refer 1.2.3.3). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records (16 November 2021).</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Additional consents were sighted for Covid-19 and flu vaccines.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record.</p> <p>Staff were observed to gain consent for day to day care.</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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical services manager provided an example of the involvement of Advocacy Services in relation to a resident contacting them independently about a personal issue. An email from the advocacy service was on file documenting that the issue had been resolved to the resident's satisfaction.</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 assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Younger people with lifelong disabilities are encouraged to participate in community activities with assistance of whānau, friends, and support workers (refer 1.3.7.1).</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A fair, transparent, and equitable system is in place to receive and resolve complaints that leads to improvements. This meets the requirements of the Code. Complaint forms and a box are at reception. Residents and whānau understood their right to make a complaint and knew how to do so.</p> <p>The complaints register reviewed showed that eight complaints have been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible.</p> <p>The care home 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. If the complaint is minor, the registered nurse talks to the complainant. Each nurses' station has a concerns notebook for minor issues which were observed to be signed off by the care manager.</p>

		<p>There have been no complaints received from external sources since the previous audit. One Health and Disability Commissioner (HDC) complaint has been investigated by management and forwarded to HDC for a response. It is yet to be closed.</p> <p>Documentation sighted on the complaints register showed that complainants had been informed of findings following investigation. The process works equitably for residents identifying as Māori. The Code is available in te reo Māori.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided and time is provided for discussion of these with staff. The Code is displayed in the reception area and outside the two nurses' stations in English, te reo Māori and sign language. This also includes information on advocacy services. Complaint/compliment forms were available at reception with a box to post them in at reception. Each nurse station has a 'minor concerns' book where staff note concerns, such as maintenance issues, and these were observed to be signed off as actioned by the care home manager.</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>	FA	<p>Residents and families, including younger people with lifelong disabilities (YPD), confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor, and participation in clubs of their choosing. The YPD are mainly independent in socialising outside the facility (refer 1.3.7.1). Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually (9 November 2021).</p>
<p>Standard 1.1.4: Recognition Of Māori Values</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values</p>

<p>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>and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions, and special needs were included in care plans reviewed. Staff are educated as part of the mandatory education provided on cultural safety and cultural appropriateness (19 November 2021). Cultural activities are included in the activities programme to celebrate the cultures represented at the facility. Church services are available to residents and their families.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care specialist, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents'</p>

conducive to effective communication.		records reviewed. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code. Staff knew how to access interpreter services, although reported this was rarely required due to the use of family members and communication cards for those with communication difficulties. The YPD were able to express their needs and preferences (refer 1.3.7.1.)
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The governing body assumes accountability for delivering a high-quality service through:</p> <ul style="list-style-type: none"> • defining a governance and leadership structure, including for clinical governance, that is appropriate to the size and complexity of the organisation • appointing an experienced and suitably qualified person to manage the service • identifying the purpose, values, direction, scope and goals for the organisation, and monitoring and reviewing performance at planned intervals • demonstrating leadership and commitment to quality and risk management • being focused on improving outcomes for Māori <p>The care home manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency within the field. The service holds contracts with the Accident Compensation Corporation (ACC), District Health Board (DHB), Ministry of Health (MoH) for YPD, respite care, complex medical conditions and palliative care. Eighty-two residents were receiving services at the time of audit; 37 residents were receiving hospital level care, including seven YPD, and 45 were in the rest home. The organisation's philosophy reflected a person centred and maximum compatibility approach between residents for this service.</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>When the care home manager is absent, the regional quality manager carries out all the required duties under delegated authority. Support is provided by the operations manager, and the clinician with quality responsibilities.</p>
Standard 1.2.3: Quality And Risk	PA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. It has executive commitment and includes management of</p>

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>Moderate</p>	<p>incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, and clinical incidents, including infections and restraint.</p> <p>Residents, whānau and staff contribute to quality improvement through meetings. The recent satisfaction survey of residents, including (YPD), was benchmarked with a good result. A corrective action plan was created to ensure outcomes were followed up. For example, a request for more interesting activities was discussed at the December residents' meeting.</p> <p>The document control system is managed by the national office. The service has not ensured all policies and procedures are current. The service was not able to provide an employment policy. Policies around laundry bag usage and cleaning of hoist slings were not evidenced.</p> <p>The care home manager described two areas where quality improvements have been made and these were sighted. Progress against quality outcomes is evaluated. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>The care home manager and the national quality and risk manager described the processes for the identification, documentation, monitoring, review and reporting of risks, including health and safety risks, and development of mitigation strategies.</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>Staff document adverse and near miss events in line with the National Adverse Event Reporting Policy. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner and signed off by the care home manager.</p> <p>The care home manager understood essential notification reporting requirements.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>A sample of nine staff files were reviewed. Position descriptions were sighted. Five of eight registered nurses hold a current interRAI assessment certificate. Three of three registered nurses have a current annual practising certificate. Annual practising certificates were sighted for the physiotherapist, pharmacist, dietitian, and all were within the expiry date.</p> <p>The care home manager reported the recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. New care staff are buddied with an</p>

		<p>experienced staff member for up to one week. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Staff performance is reviewed and discussed at regular intervals. The care home manager uses a checklist to ensure employment practices are met. The checklist was sighted. New employee documents are forwarded to the national support office for processing. The care home manager reported that all documents must be processed before an employee begins their employment.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. There is a documented and implemented system to ensure competency assessments are completed and this supports equitable service delivery. Where training has not been completed, additional training sessions are held for staff to complete requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The documented and implemented process, 'Safe Rostering tool', is used for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7).</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. Care staff reported there were adequate staff to complete the work allocated to them. Residents and whānau interviewed supported this. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the facility. Observations and review of a six-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence.</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>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current, integrated and legible and met current documentation standards. This includes interRAI assessment information entered into the Momentum electronic database. George Manning Lifecare uses an electronic system for residents' files. GP and allied health service providers have access to document in the files. Each staff member has a unique password to maintain privacy and only have access to information pertinent to their scope of practice.</p>

		<p>Residents' files are held securely for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Archived records are held securely on site and are readily retrievable.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Relevant NASC assessments and authorisations for YPD were completed.</p> <p>Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. Family members and residents interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission and that opportunity was provided for discussion with staff.</p> <p>Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHBs 'yellow envelope' system and at the time of transition between services, appropriate information is provided for the ongoing management of the resident using the aged residential care transfer form. There is open communication between all services, the resident and the family/whānau. All referrals are documented in the progress notes. Family communication during a transfer of relative was documented in a file reviewed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. All staff who administer medicines are competent to perform the function they manage and understood their roles and responsibilities.</p> <p>Medications are supplied to the facility from a contracted pharmacy. Medication reconciliation occurs. All medications sighted were within current use by dates.</p> <p>Medicines are stored safely, including controlled drugs. The required stock checks have</p>

		<p>been completed. Medicines were stored were within the recommended temperature range.</p> <p>Prescribing practices meet requirements. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were two residents who were administering their own medication. Appropriate assessments, documentation and review by the GP was in place. The residents keep their medicines in a drawer out of sight, but these are not lockable, resulting in a corrective action.</p> <p>Residents, including Māori residents and their whānau, are supported to understand their medications.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>	FA	<p>The food service is provided on site by three cooks and kitchen team and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (3 December 2020). No recommendations were made at that time.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The service operates with an approved food safety plan and registration issued by Christchurch City Council - current until 4 September 2022. All kitchen staff have attended in-service training (2 September 2021).</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and in resident meeting minutes.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion, and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are</p>

<p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed.</p> <p>There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. (refer 1.3.3.3 above) Residents and families confirmed their involvement in 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>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the majority of care plans reviewed (refer 1.3.3.3).</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff at handover.</p> <p>Residents and families reported participation in the development and ongoing evaluation of 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>Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP was interviewed and verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. The YPD had their own equipment.</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>PA Low</p>	<p>The activities programme is provided by two trained diversional therapists (DT) holding the national Certificate in Diversional Therapy. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated by observing resident engagement and as part of the formal six monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered.</p> <p>Residents and families/whānau are involved in evaluating and improving the programme through monthly residents' meetings with each resident receiving a copy of the meeting minutes. Residents interviewed confirmed they find the programme varied and interesting and were observed to be actively engaged on the day of audit.</p> <p>There are seven younger residents in the facility. In the past, activities and meetings were scheduled with poor attendance, so they were discontinued. They sort out their own activities and outings and were happy doing this.</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' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN using a 'stop and watch' tool.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated as observed in the case of a chronic wound.</p> <p>Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Residents may choose to use the 'house doctor' or another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files for the</p>

<p>other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>wound nurse specialist. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building warrant of fitness expires on the 1st of January 2022.</p> <p>Electrical equipment has been tested as required. Tagging and records were viewed.</p> <p>The facility meets the needs of residents and was clean and well maintained. Furniture is appropriate to the setting and residents' needs.</p> <p>External areas are accessible, safe and provided shade and seating, and meet the needs of people with disabilities. The maintenance personnel described the maintenance schedule.</p> <p>All bedrooms provide single accommodation and were personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheelchairs and mobility scooters.</p> <p>Consultation included the 'voice of a resident' who identified as Māori during the planning of the rebuild of the west wing following the Christchurch earthquake.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers</p>	<p>PA Moderate</p>	<p>Each resident has their own en-suite. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility for visitors and staff. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment and accessories are available to promote residents' independence.</p>

are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		The hot water reading in three rooms exceeded 45°degrees on the day of the audit.
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	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Residents and whanau reported they were happy with the environment.
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	Communal areas are available for residents to engage in activities. Four dining rooms and two lounge areas are spacious and enable easy access for residents and staff. Residents and whanau reported they were happy with the environment.
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	Laundry is undertaken on site by dedicated laundry staff who demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. There is a small, designated cleaning team who have received appropriate training. These staff undertake the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and review of training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Policies were not evidenced for either the use of laundry bags or for the cleaning of hoists, although staff were able to explain the process. (refer 1.2.3.4).
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. Staff files evidenced staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Staff files evidenced registered nurses have a current first aid certificate. At least one staff member on duty has a

		<p>current first aid certificate. The orientation programme includes fire and security training. Fire extinguishers, alarms, fire action plans, call boxes, floor plans with exits, hose reels, and sprinklers were sighted.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 12 December 2018. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on the 19th of October 2021.</p> <p>Adequate supplies for use in the event of a civil defence emergency including blankets, mobile phones, torches, medical supplies and water were sighted and meet the requirements for the residents. Food is kept in the kitchen. Gas is supplied to the kitchen for cooking. A water storage tank is on site. Residents are informed of the emergency and security arrangements on admission to the service and again at residents' meetings. The service signed a memorandum of understanding with the neighbouring school on 17 September 2021, giving the service access to use the hall for emergency accommodation.</p> <p>Appropriate security arrangements are in place. Windows have security stays. Doors and windows are locked at 6pm and a security company checks the premises each 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>	FA	<p>Heating is provided by individually controlled radiators in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. Residents were happy with the environment, including heating and ventilation, privacy and maintenance.</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>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description, the role is overseen by the clinical services manager (CSM). Infection control matters, including surveillance results, are reported monthly to the care home manager, and tabled at the quality/risk meeting.</p> <p>QR codes are available at the main entrance, as is sign in declarations and temperature scanning equipment. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these</p>

		responsibilities.
<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 IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has only been in this role a short time. They are supported by the CSM. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required.</p> <p>The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</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 infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2021 and included appropriate referencing.</p> <p>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.</p> <p>Hand washing and sanitiser dispensers were readily available around the facility.</p> <p>Staff interviewed verified knowledge of infection control policies and practices.</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>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred during a gastrointestinal event and a Covid-19 outbreak. Both events were clearly documented, and appropriate documentation was sighted and signed off.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing and advice about remaining in their room if they are unwell.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies.</p> <p>The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical services manager and reported at the quality meeting. Data is benchmarked within the group and externally with other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>Summary reports for a recent gastrointestinal infection outbreak and Covid-19 outbreak were reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the events have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Maintaining a restraint free environment is the aim of the service. The business plan demonstrated commitment to this. Monthly reports are forwarded and discussed at the quality meeting. Minutes from that meeting are forwarded to the national quality and risk meeting.</p> <p>When restraint is used, this is as a last resort when all alternatives have been explored. At the time of audit, one resident was using a restraint.</p> <p>One resident had requested and consented to using an enabler in the form a bed rail and was able to lower it without support.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining</p>	<p>FA</p>	<p>The clinical nurse manager reported she is the restraint coordinator. The position description was sighted. There are clear lines of accountability.</p> <p>Staff interviewed and records confirmed attendance at de-escalation and safe restraint</p>

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.		minimisation and safe practice training. Annual competency records were sighted.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The assessment for the use of restraint were documented and included all requirements of the Standard. The restraint co-ordinator explained the process. The enduring power of attorney (EPOA) was involved in decision making, as was appropriate.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint approval group, including the clinical nurse manager, are responsible for the approval of the use of restraints and the restraint processes. The use of restraint is being monitored hourly, documented and analysed. A restraint register is maintained and reviewed at each restraint approval group meeting. The register contained enough information to provide an auditable record. There have been no episodes of emergency restraint.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint co-ordinator explained the requirements of the evaluation of restraint process. Evidence was sighted and included all requirements of the Standard.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	PA Low	The restraint group undertook a review of all restraint use between September 2019 and December 2021. The review did not include the review of the policy and procedures. The outcome of the review is reported to the governance body. The use of restraint has been reduced by eight following the review. The use of alternative solutions, such as sensor mats, high-low beds and mattresses, have been introduced.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Moderate	Forty percent (40%) of the policies and procedures were out of date. The provider was aware of this. The care home manager and the national quality and risk manager reported that the reviewed policies and procedures were due to be released the day after the audit.	Forty percent (40%) of policies and procedures were not current at the time of audit.	<p>Provide evidence that the policies and procedures are current.</p> <p>90 days</p>
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	PA Moderate	The service was not able to provide an employment policy. Policy was available for laundry practices but despite the presence of different coloured laundry bags there was no guidance on what colour laundry	The service provider has not developed and implemented an employment policy. Policies around laundry practices	Provide evidence that an employment policy has been developed and

		<p>bag was used for what product (for example, separate coloured bags for personal laundry and kitchen laundry). Cleaning policy has no reference to the cleaning of reusable equipment (for example, sling hoists).</p>	<p>need specific guidance on the use of different coloured laundry bags for different laundry products. Policies on cleaning need to include the process for cleaning of reusable equipment (for example, hoist slings).</p>	<p>implemented in accordance with good employment practice to meet the requirements of legislation.</p> <p>Provide evidence of policies in relation to laundry bag usage and cleaning of reusable equipment (for example, hoist slings).</p> <p>90 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA</p> <p>Moderate</p>	<p>Residents who administer their own medications are appropriately assessed and reviewed as competent to do so by a registered nurse and GP on a regular basis, as confirmed in files reviewed.</p> <p>Interviewing the residents confirmed they were competent and understood their responsibilities, but do not keep medicines secure at all times as no locked receptacle has been provided by the facility.</p>	<p>The residents who administer their own medications do not have a secure place to store them.</p>	<p>A locked receptacle is provided for storage of medicines.</p> <p>30 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>Staff interviewed were aware of residents needs and interventions were carried out appropriately according to the plan of care. Three out of ten files reviewed showed that initial long term care plans, dating back to admission in 2019, were developed before interRAI assessments were completed so information obtained from interRAI assessments were not used to inform the care plan.</p>	<p>interRAI assessments are completed, however, they are completed after the LTCP is written, which is not consistent with contractual requirements around development of individual care and support plans in a timely manner.</p>	<p>InterRAI assessments are completed before the long term care plans are developed.</p> <p>180 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>Younger residents spoken to are happy to independently access community events (such as shopping/movies/outings) and are assisted in this by family and friends. Previously there was a programme, however low attendance resulted in cancellation, leaving these residents without a formal programme or the opportunity to have input into one.</p>	<p>The younger residents do not have a programme provided that caters for their interests and abilities.</p>	<p>Ensure the younger residents have the opportunity to attend planned activities that are age appropriate.</p> <p>60 days</p>
<p>Criterion 1.4.3.1</p> <p>There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.</p>	<p>PA Moderate</p>	<p>A random sample on the day of the audit showed the hot water in three residents' rooms exceeded 45°C degrees. The water was 52.6°C degrees. The hot water readings in some residents' rooms exceeded 45°C degrees at a recent audit. A contractor advised a tempering value needed to be replaced. The</p>	<p>The hot water reading in three rooms exceeded 45°C degrees on the day of the audit.</p>	<p>Provide evidence that the hot water in all residents' rooms does not exceed the required 45°C degrees.</p>

		work was to be completed as soon as possible. The care home manager reported that signs warning people that the hot water exceeded the recommended standard is put in all rooms. This includes staff and visitor bathrooms.		30 days
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	PA Low	The restraint group undertook a review of all restraint use between September 2019 and December 2021. The review did not incorporate the review of the policy and procedures. The policy was out of date however it did meet the requirements of the standard.	The provider has not conducted a comprehensive review at least six-monthly of all restraint practices used by the service in line with the specific standard requirements.	<p>Provide evidence of a comprehensive review at least six-monthly of all restraint practices used by the service in line with the specific standard requirements.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.