

# Experion Care NZ Limited - Greendale Residential Care

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Experion Care NZ Limited	
<b>Premises audited:</b>	Greendale Residential Care	
<b>Services audited:</b>	Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 25 January 2022	End date: 26 January 2022
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	23	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Greendale Residential Care provides rest home level of care for up to 24 residents. There were 23 residents at the time of the audit. Residents and families report satisfaction and positivity about the care, services, and activities provided. The service is one of six facilities owned by Experion Care NZ Limited. The only significant change to the facility or services was the recruitment of the clinical manager (CM) in August 2021. The clinical manager (CM) has been running the service with the assistance of the other nurse manager (NM) from the sister facility.

This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, relatives, staff, management, and general practitioner.

This audit resulted in one identified area requiring improvement relating to the medication management system specifically centred on documentation of effectiveness for pro re nata (PRN) outcomes and dating of eye drops when opened.

## 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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The Code of Health and Disability Services Consumer Rights (the Code) is incorporated into the service's policies and procedures, and into everyday practice in the way care and support is provided. Residents who were interviewed advised that they are aware of their rights and can choose what they want to do. They confirmed that there is good communication from staff.

Residents are treated with dignity, respect, and understanding. Privacy is respected and ongoing family involvement is encouraged. Cultural and spiritual values, beliefs, and wishes are identified and supported. There is ongoing contact with the local Health and Disability Advocate.

Residents can participate in a range of activities, both within the service and in the wider community. They are supported and encouraged to be as independent as possible.

There is no evidence of abuse or neglect, or any discrimination, coercion, harassment, sexual, financial, or other exploitation. Residents and family members who were interviewed spoke very positively about the care and support provided.

The complaints process meets consumer rights legislation, and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation is governed by Experion Care NZ Limited. Day-to-day operations are the responsibility of the clinical manager with oversight from the nurse manager from the other sister facility. Organisational performance is monitored. Business and quality risk management plans are current and have been reviewed.

The quality and risk management system includes the collection and analysis of quality improvement data, identifies trends, and leads to improvements. Staff is involved, and feedback is sought from residents and families. All adverse events are documented, and corrective actions are in place. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were reviewed regularly.

Processes for the appointment, orientation, and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance reviews. Staffing levels and skill mix meet the changing needs of residents.

Resident information is held securely and meets all requirements of the standards.

## Continuum of service delivery

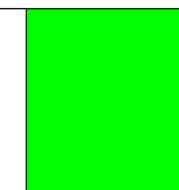
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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All stages of service provision were completed in a timely and competent manner, the clinical manager (CM) assesses and develops care plans in consultation with the residents and their family. The residents' needs and care requirements are evaluated as required. The required personal care and clinical interventions are implemented. InterRAI assessments and individualized care plans are documented. Medication management policies reflect legislative requirements and guidelines. All medications are reviewed by the general practitioner (GP) every three months or when required. Medicines are safely managed, stored, and

administered by staff with current medication administration competencies. Improvement is required to ensure outcome on PRN medication documented for effectiveness, and all used eye drops have an opening date.

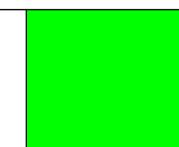
The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. The food service is provided onsite and caters to residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. food control plan and dietitian menu review were in place and valid.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility is appropriate to the needs of residents and is clean and well maintained. Appropriate policies and procedures are available along with product safety charts. Chemicals are stored safely throughout the facility. There is a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. All areas are accessible to people with a disability. External areas are safe and well maintained. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. 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

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The required processes for the minimisation and safe management of restraints and enablers are in place. The NM is the restraint coordinator. There were no residents using restraint or enablers at the time of the audit. The restraint policy outlines that the use of enablers shall be voluntary to promote residents' independence and safety.

## 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 CM is the prevention and control coordinator, has the appropriate skills, knowledge, and qualifications for the role, and has attended training related to infection prevention and control. There are policies and procedures to guide practice. The surveillance programme is appropriate to the size and scope of the service. Staff receive training in infection prevention and control.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	44	0	1	0	0	0
<b>Criteria</b>	0	92	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and the annual in-service education programme. Residents' rights are upheld by staff. For example, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, with staff calling residents by their preferred names. Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents. The last training on the Code was conducted by the Nationwide Health and Disability Advocate Service in February 2021.</p> <p>The residents interviewed confirmed that they are treated with respect and understand their rights. The family/whānau reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</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 sampled verified that informed</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>consent had been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA), where applicable. The general practitioner makes a clinically based decision on resuscitation authorisation.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. An advance directive and advance care plan are used to enable residents to choose and make decisions related to end of life care. Some files reviewed had signed advance care plans that identify residents' wishes and meet legislative requirements.</p> <p>Staff was observed to gain consent for day-to-day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' 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>As part of the admission process residents and family/whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents were aware of the advocacy service, how to access this, and their right to have support persons. The CM and staff provided examples of the involvement of advocacy services concerning residents' care.</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. All residents are assisted in accessing community resources and mainstream support. Family/whānau or friends are encouraged to visit or call.</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 encounters with staff.</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>The service has a complaints management policy and procedure in place that aligns with Right 10 of the Code. The services complaint register is detailed regarding dates, timeframes, complaints, and actions taken. All complaints in the register had been resolved. There was one complaint in 2021 and no complaints so far in 2022. Complaints information is used to improve services as appropriate. Quality improvements or trends identified are reported to staff. Residents and families are advised of the complaints process on entry to the service. This includes written information about making complaints. Residents interviewed describe a process of making a complaint that includes being able to raise these when needed or directly approaching staff or the facility manager. It was reported that there have been no complaints made to external authorities since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their family/whānau, as confirmed in an interview with the clinical manager (CM). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally during daily care. Education is held by the Nationwide Health and Disability Advocacy Service annually.</p> <p>Resident agreements signed by either the residents or enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements. Residents are addressed in a respectful manner and by their preferred names as was confirmed in an interview with residents.</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</p>	<p>FA</p>	<p>There is a policy and procedures regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms, and reporting requirements. Staff respect and allow residents to express their personal, gender, sexual, cultural, religious, and spiritual</p>

<p>independence.</p>		<p>identity. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice.</p> <p>Residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence. Some residents receive respite care, day care services, mental health services, care for long-term chronic health conditions (LTCHC), and rest home level of care. Records sampled 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>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>Greendale Residential Care acknowledges its responsibility in its current operations to Māori residents. The CM confirmed that the service responds in accordance with the Treaty of Waitangi taking into consideration Māori Health Strategy and the Māori Health Plan. Assessments and care plans will document any cultural and spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. Cultural staff training is incorporated into the staff annual in-service education calendar. There were no residents who identified as Maori and there were four staff members of Māori descent. Policies and procedures regarding the recognition of Māori values and beliefs are documented.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner following protocols/guidelines as recognised by the resident and family/whānau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents confirmed they were encouraged to be</p>

		involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in the care plans reviewed.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members stated that residents were free from any type of discrimination, harassment, or exploitation and felt safe. Residents interviewed reiterated the same. The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of conduct. A code of conduct statement is included in the staff employment agreement. 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. The clinical manager (CM) stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents.</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, diabetes nurse specialists, wound care specialists, mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and was responsive to medical requests.</p> <p>Staff reported they receive management support to attend external education and access their professional networks to support contemporary good practice. There is specific training and education to assist the staff to manage residents safely. The care staff has either level two, three or four New Zealand Qualification Authority certificates.. The activities programme evidenced good practice for residents assessed as requiring all levels of care provided by the provider.</p>
Standard 1.1.9: Communication	FA	Family members stated they were kept well informed about any

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews This was supported in residents' records sampled. Staff understood the principles of open disclosure, which are supported by policies and procedures. Personal, health, and medical information are collected to facilitate the effective care of residents.</p> <p>The CM reported that a variety of external resources, including support groups and interpreter/translation services, are accessed as required. The staff further reiterated that residents and relatives who are not conversant with the English language are advised of the availability of interpreter services at the first point of contact. There were no residents who required the services of an interpreter; however, the staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service was originally set up in the early 1990s by the previous owners and it was acquired by Experion Care NZ Ltd in 2016. The 2018-2022 strategic and business plan documents describe annual and long-term objectives and the associated operational plans. The strategic and business plan sighted included the scope, direction, goals, values, and mission statement of the organisation. The future growth plans of the organisation outlined in the strategic business plan are, looking at converting the service into a swing bed facility offering stage-2 and hospital level of care services. The clinical manager and the nurse manager from the other sister facility reported that the service was certified for 25 beds. Monthly reports to the executive director (owner) showed adequate information to monitor performance is reported including potential risks, contracts, human resource and staffing, growth and development, maintenance, quality management, and financial performance.</p> <p>The service is managed by the CM with oversight from the nurse manager from the other sister facility, ensuring adequate coverage both onsite and after-hours. They are both supported by the executive director (owner). The management team meets on regular basis. All</p>

		<p>members of the management team are suitably qualified and maintain professional qualifications in management, finance, and clinical skills. Both managers are registered nurses with current practising certificates and attend regular conferences conducted by the local district health board. The CM was employed by the service in August 2021 and has been previously actively involved in management duties for seven years in the health care sector. The NM who was providing oversight eight hours a week, has resigned and was serving the notice period and will be officially relinquishing the role on 28 January 2021. Responsibilities and accountabilities are defined in a job description and individual employment agreement.</p> <p>The service holds contracts with the district health board (DHB), ministry of health (MOH) for the provision of rest home care, mental health, respite and day care services, and long-term support chronic health conditions (LTS-CHC). There were 23 residents receiving services on the day of the audit. At the time of the audit, there were 20 residents assessed as requiring rest home level of care, three (3) under the mental health contract, and one resident attending day care services three times a week.</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 CM is absent, the CM from the other sister facility carries out all the required duties under delegated authority. The CM will be supported by the owner/director. Staff reported the current arrangements to work well. Responsibilities and accountabilities are defined in a job description and individual employment agreements.</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>Greendale Residential Care has a planned quality and risk management system that reflects the principles of continuous quality improvement. The quality and risk programme includes compliments and complaints management, internal audits, satisfaction surveys, incident and accident reporting, hazard management, health and safety, restraint minimisation, infection control data collection, and management.</p> <p>Meeting minutes are available for staff to read. These confirmed</p>

		<p>regular reviews and analysis of quality indicators and that related information is reported and discussed at the management team and staff meetings. Staff interviewed confirmed their involvement in quality and risk management activities through internal audit activities. Regular internal audits are conducted, which cover relevant aspects of service including medication management, documentation, food services, and the facility/equipment. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed yearly and confirmed general satisfaction with the services provided.</p> <p>Policies and procedures are available to guide staff practice, and these were based on best practices and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. These are managed by an external consultant who keeps the service updated on any recent changes through emails with updated policies and procedures.</p> <p>Both managers described the process for the identification, monitoring, review, and reporting of risks and the development of mitigation strategies. The CM, NM, and owner/director are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded. The service's financial position is managed and audited by an accounting consultancy and the annual financial report is provided. The required insurances are in place.</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 the electronic record management system. A sample of incident entries reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up in a timely manner. Neurological observations are completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed, and reported to the management, respectively. There is an open disclosure policy in place. Any communication with a family and general practitioner (GP) following adverse events and if there is any</p>

		<p>change in the resident's condition are recorded in residents' records. Family/whanau and the GP interviewed confirmed they are notified promptly.</p> <p>The CM and NM described essential notification reporting requirements, including pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks, and missing persons. The only notification reported to MOH was that of the appointment of the CM in August 2021.</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>	FA	<p>Recruitment and staff management follow employment guidelines and relevant legislation. The required policies and procedures are documented. All employees sign employment agreements with position descriptions and roles stated. Reference checks were conducted. Police vetting and validation of qualifications and annual practicing certificates (APCs), where required, were attained. The nursing and other medical staff had current practicing certificates. Other employees like the cook and health care assistants met training and qualifications for their roles.</p> <p>All staff performance appraisals were conducted within the current year. Mandatory training such as infection control, medication competencies, first aid, fire drills, restraint, and InterRAI competencies were attained. New employees were oriented to the essential components of service delivery. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the providers' agreement with the DHB. Residents and family interviewed stated that staff are knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The roster indicated that there are always sufficient numbers of staff available on every shift for twenty-four hours. Level of skill and experience is considered when rostering staff and this is documented. The service employs one CM, 10 full-time health care assistants (HCA), and three casual staff. Staff on sick, bereavement or annual leave were immediately replaced and had their shifts covered by</p>

		<p>either other regular or casual staff. Changes were made to staffing levels to meet the changing needs of residents when required. Staff reported that there is access to advice when needed.</p> <p>The service has designated cleaning, cooks, kitchen hands, diversional therapist, and maintenance staff. Laundry is washed by HCAs. Residents expressed satisfaction with staff availability and having needs met promptly, responding quickly when residents needed them or when they rang the call bell. Two level-four HCAs alternate the on-call weekend cover mainly focussing on staffing issues and non-complicated resident issues. The CM and NM are either on-site or easily contacted by phone when needed.</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>	FA	<p>A resident register of all current and past residents is maintained. Resident individual information is kept electronically, and paper-based. The resident's name, date of birth, and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical, and health information was fully completed in the residents' files sampled for review. Records of inquiries that are declined are maintained in a paper record. There was evidence that unsuccessful inquiries are referred to their referrer for alternative providers that may suit their needs. Clinical notes were current and integrated with GP and allied health service provider notes.</p> <p>Archived paper records are held securely on-site and are readily retrievable using a cataloguing system. The electronic records are backed up in the Cloud-based system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>The Clinical Manager is responsible to manage the admission process at the service. Residents enter the service when the required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) agency. Prospective residents and/or their families are encouraged to visit the facility</p>

		<p>before admission and are provided with written information about the service and the admission process. Evidence sighted in sample records confirmed all entry requirements were conducted within the required time frames in a competent and timely manner. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission in a respectful manner. Files reviewed contained completed demographic detail, assessments, and signed admission agreements following contractual requirements. The contracted GP visits fortnightly, reviews residents on admission and is available 24/7 by mobile for visits at any other time, In addition, the designated medical centre cover after-hours alternatively as confirmed by the GP. The sampled medical records included evidence the GP had seen the resident within the required time frame and had examined the residents at least three monthly or more frequently as required.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge, or transfer is managed in a planned and coordinated manner, with an escort/family member as appropriate. There is open communication between all services. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident. All referrals are recorded in the progress notes. Residents and family/whanau are supported to access or seek a referral to other health and/or disability service providers when required or if the need for other non-urgent services is indicated or requested, Family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the CM. GP interviewed confirmed timely and competent transfer for emergency cases at the rest home.</p>
<p>Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements.  RN and senior HCAs who administer medications have been</p>

		<p>assessed for competency on an annual basis. Education around safe medication administration has been provided. Care staff interviewed described their role regarding medication administration. Medication round by competent HCA observed meets the guidelines and requirements. Ten medication charts were reviewed on the electronic medication system. Administration charts demonstrate that medication is being administered as prescribed. All medication charts had been reviewed at least three monthly and as required by the GP. Medication charts met the legislative requirements for the prescribing of regular medications. reconciliation is conducted by the CM when a resident is transferred back to service</p> <p>All prescriptions for 'as required' medications document the indication for use.</p> <p>Medications were stored safely in a medication room. There were no residents self-administering medications at the service in the audit days. The staff was aware of self-administration medication policy requirements. Weekly and six-monthly controlled drug stock takes are conducted, and Pharmacists signing in drug control register sighted. Monitoring of medication fridge temperatures and medication storage room is conducted, and records were sighted.</p> <p>The previous Audit concern related to medicine management "Audit Corrective Action "has been addressed and resolved.</p> <p>An improvement is required to ensure PRN medication outcome is documented, and eye drops in use have an opening date.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management 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 current food service is satisfactory to accommodate the needs of the residents. Meal services are prepared on-site and served in dining rooms. The residents' weights are monitored monthly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required. There is a four-weekly seasonal rotating menu in use. Diets are modified as required and the cooks confirmed awareness of the dietary needs of the residents. Alternative meal options are offered as required. A nutritional profile is developed on admission and reviewed every six months or when there is any significant change. Meals are</p>

		<p>served warm in sizeable portions required by residents and any alternatives are offered as required. The cook on duty reported feedback is taken from residents in food satisfaction meetings with residents and on a one-to-one basis. Evidence of resident satisfaction with meals was verified by resident and family interviews, and auditor observation. Residents were given time to eat their meal in an unhurried approach and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed. Dietitian monitoring and audit report sighted; the menu has been reviewed by registered dietitian within the last two months. The chef reported kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges, and freezers temperatures are maintained. Regular cleaning is conducted. The kitchen is registered under the food control plan. Certificate of kitchen audit by relevant body valid until September 2022.</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b> 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>FA</p>	<p>There is a documented policy on the decline of entry to the service. When a consumer's entry to the service is declined, the resident/whanau is referred to the referrer to ensure that the resident is admitted to the appropriate level of care provider. The reason for declining entry is communicated to the referrer, consumer, and their family or advocate in a timely and compassionate manner. Where requested, assistance would be given to provide the consumer and their family with other options for alternative health care arrangements or residential services.</p>
<p><b>Standard 1.3.4: Assessment</b> Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Residents have their level of care identified through needs assessment by the assessment agency. Initial nursing assessments are completed within the required time frame on admission while residents' care plans and InterRAI assessments are completed within three weeks as per the sample medical records sighted. Assessments and care plans were detailed and included input from the</p>

		<p>family/whanau, residents, DHB Nurse specialist, and other health team members as appropriate. Additional assessments are completed according to the need and these included pains, behaviour, falls risk, nutritional requirements, continence, skin, and wound assessments. The dietary requirements support resident preferences and choices of food. The activities coordinator completes the resident activities plan including resident activity selection and preferences. The nursing staff utilized standardized risk assessment tools on admission. The information gathered is documented and informs the planning process. This takes place in the privacy of the resident's bedroom with the resident and/or family/whanau present where possible. A medical assessment is undertaken within 1- 3 days of admission and reviewed as a resident's condition changes, or three monthly as evident by the resident medical record. In interviews conducted, family/whanau and residents expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans are resident focussed, integrated, and provide continuity of service delivery. Assessments were completed in a timely manner. Long-term and short-term care plans are developed for acute and long-term needs. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and family/whanau interviewed confirmed care delivery and support are consistent with their expectations and the plan of care.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The documented interventions in short-term care plans and long-term care plans were sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported, updated, and documented; prescribed orders are carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date.</p> <p>Wound assessment, monitoring, wound management plans and short-term care plans are in place as required. The CM has access to</p>

		<p>specialist wound care management advice through the district health board (DHB) as required. Clinical supplies are adequate, and the staff confirmed they have access to the supplies and products they needed. Personal protective equipment and continence products are available and seen during the audit days. Care workers and RNs interviewed stated there are adequate personal protective equipment, continence, and wound care supplies.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is managed and provided by a qualified Diversional Therapist (DT) who covers five weekdays. On weekends the activities are continued in coordination with family members and volunteers. There are planned activities and community connections that are suitable for the residents. The DT reported the resident's cultural requirements and preferences are taken into consideration. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. Activities plans are evaluated every six months, and information integrated into the InterRAI Assessment and LTCP. Evidence in the activities assessment, schedule, and related plans have been Sighted. monthly planner is distributed to all residents and posted on the notice boards that are accessible to residents. A resident preference/choice of activities form is completed on admission. The activities provided take into consideration residents' interests and abilities. Residents and their family/whanau are consulted in the activity's assessment and planning process. There is a wide range of activities offered: including bingo; word building; and music sessions. Van trips occur twice a week targeting popular destinations. Monthly residents' meetings are conducted, and outcomes are implemented and communicated to family/whanau and residents. Updated activities are on the Facebook private group page. Family interviewed, residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit. Community involvement includes external entertainers. Daily activities attendance checklist is completed, and evaluation of individual activity plans is completed six monthly. Activities include group and one-to-one and cater for those with mental health disorders and for under 65 years of age. Community visits and activities have been restricted due</p>

		to Pandemic covid 19 as reported by the DT.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>There was evidence that residents' care plans are personalized and reflect InterRAI assessments and other resident assessments. Initial care plans were evaluated by the CM within three weeks of admission. Long-term care plans have been evaluated by the registered nurses six-monthly or earlier for any health changes in the resident. Activity plans are evaluated at least every six months and updated when there are any changes. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short-term care plans are developed when needed, evaluated, closed out when the short-term problem has been resolved, or integrated with the long-term care plan if not resolved. The family is consulted in the review process. Written evaluations identified if the resident's goals had been met or unmet. Ongoing nursing evaluations occur as indicated and are documented in the evaluation form and progress notes. There is at least a three-monthly review by the GP. All changes in health status are documented and followed up, changes and updates in the set plans documented and actioned accordingly.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The CM confirmed that processes are in place to ensure that all referrals are followed up accordingly. GP and the nursing team send a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up regularly by the CM or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to, and the resident is transferred to the public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous</p>	FA	<p>The facility policy describes safe and appropriate storage and disposal of waste, infectious or hazardous substances, including storage and</p>

<p><b>Substances</b></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>use of chemicals. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. No hazardous substances were detected on site. The CM, NM, cook and care staff interviewed demonstrated awareness of safety and appropriate disposal of waste. Used continence and sanitary products are disposed of appropriately in proper disposal containers stored in a safe place outside.</p> <p>There were sharps boxes in the medication room. Toiletries and cleaning chemicals are locked up in a room. Personal protective equipment was readily available. Staff was observed to be using personal protective equipment, including changing gloves after every procedure.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></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 current building warrant of fitness was displayed and expires on 1 November 2022. The service has a nine-seater van that has a current warranty of fitness. There were sealed fire extinguishers inside, and a fire hose outside. Annual electrical testing is completed by a certified electrician, and this was confirmed in documentation review, interviews with maintenance personnel, and observation of the environment. Fire safety equipment is checked monthly by an external agency. Calibration of scales and medical equipment occurs annually. There were documents to support this.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Hot water checks are conducted monthly, with all readings below the maximum temperature range.</p> <p>The corridors are wide enough to enable mobility aids and fitted with handrails to encourage independent mobility. Each resident room has direct external access to courtyards and garden areas. There are concrete ramps to enable disability access. Residents can walk around freely throughout the facility and grounds. The gardens and courtyard were well maintained and tidy.</p> <p>Environment hazards are identified and monitored as per the health and safety system. Residents and staff confirmed they know the processes they should follow if any repairs or maintenance are</p>

		required, any requests are appropriately actioned, and that they are happy with the environment.
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></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>	FA	<p>There are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. There were two ensuites, three bathrooms, five showers, and 23 toilets. The toilets, doorways are wide and accessible for residents who require mobility aids. There are secure handrails for the residents to use for support and to promote residents' independence. Each toilet door is lockable with working 'engaged/vacant' signs for privacy. Each bedroom has a hand basin. Toilets, bathrooms, and showers had doors or curtains to provide privacy for users. Toilets, bathrooms, and showers were clean and well maintained.</p> <p>The temperature of the hot water in every resident room, laundry, and kitchen is tested and recorded monthly. All hot water temperatures were within safe recommended ranges of below 45 degrees in residents' rooms this includes showers, baths, and hand basins. Water cylinders at 60 degrees Celsius while in the laundry and kitchen areas it was set at 55 degrees Celsius max. Visitor and staff toilet is available at the facility.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are 21 single bedrooms with a toilet and hand basin and three double rooms usually used by couples. Personal privacy is maintained. Rooms are personalised with furnishings, photos, and other personal items displayed. Doorways are wide enough for wheelchair access if required. There was space for mobility aids. Residents with mobility aids were observed to be moving in and out of the rooms with ease. Staff and residents confirmed the adequacy of bedrooms.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p>	FA	<p>Communal areas are available for residents to engage in activities and are kept warm by heat pumps, wall heaters, and electric fans. The</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>bedrooms have electric heaters. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy if required. Furniture is appropriate to the setting and residents' needs.</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>	<p>FA</p>	<p>All laundry is washed on-site or by family members if requested. The family/whanau interviewed expressed satisfaction with the laundry management and the clothes are returned on time. There are designated cleaning personnel who have received appropriate training. Chemicals were decanted into appropriately labelled containers. The staff attend chemical safety training annually. Material safety data sheets for each of the products were readily accessible. Chemicals are stored in labelled containers in a locked room. The effectiveness of cleaning and laundry processes is monitored through the internal audit programme and corrective actions are acted upon. All residents and family members interviewed reported that the environment was clean and were satisfied with laundry services.</p> <p>Care staff demonstrated a sound knowledge of the laundry processes. There is a clear separation of clean and dirty areas in the laundry.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The facility has an approved evacuation plan, and an evacuation policy is in place. Fire drills take place every six months and this was documented. All staff complete fire training and participate in a fire drill. Orientation for new employees includes emergency and security training. Staff demonstrated awareness of emergency procedures. There is always at least one staff member on duty with a first-aid certificate.</p> <p>There are adequate fire exit doors and the courtyard is the designated assembly point. All required fire equipment is checked within the required timeframes by an external contractor. A civil defence plan was in place. Adequate supplies in the event of a civil defence emergency including food, water, candles, torches, and a gas BBQ meet The National Emergency Management Agency recommendations for the region. A generator will be hired if required.</p>

		<p>Emergency lighting is regularly tested.</p> <p>A security check is done by the afternoon and night staff when all doors are locked. External lighting is adequate for safety and security. The call bell system is operational with bells in each room. Those tested on the days of the audit were working and staff responded to call bells promptly. Residents interviewed confirmed that staff attends promptly when a bell is activated. There are labels on the walls to indicate call bells.</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 residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto the outside garden or small patio areas. Heating is provided by heat pumps with wall panel heaters available for supplementary heating if required in residents' rooms and 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. The service has an external designated smoking area away from the building for residents who smoke.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an appropriate infection prevention and control programme. The role of the infection control coordinator has access to external specialist advice from the GP practice and DHB infection control specialists when required. The infection control programme is approved and reviewed annually. Infection rates are discussed at monthly staff meetings. Staff is made aware of new infections through daily handovers on each shift and reporting. There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme and knew that they are required to report residents who are suspected of</p>

		having infections to the CM promptly. The staff was able to identify the importance of hand hygiene and using standard precautions. Covid-19 information is shared and accessible to all staff to read. IC Poster and Covid 19 information displayed. Residents are closely monitored for any signs and symptoms. Personal Protective Equipment (PPE) stock was sighted. All Residents received Covid 19 vaccination except one resident as per his choice and family wish. All staff received Covid 19 vaccination. majority had the booster dose and few in process of completing .
<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 infection prevention and control coordinator (ICC) has appropriate skills, knowledge, and qualifications for the role and has attended specific education related to infection prevention and control. Additional support and information are accessed from the infection control team at the DHB, and the GP as required. The infection control coordinator has access to records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential 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 reflect the requirements of the infection prevention and control standards and current accepted good practice. Policies and procedures were reviewed. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitizers, good hand washing technique, and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures. Staff interviewed demonstrated awareness of Covid 19 protocol and prevention. No respite residents accepted during Covid 19 pandemic, referred to NASQ for community home care.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control</p>	FA	<p>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. The ICC attended an infection</p>

<p>to all service providers, support staff, and consumers.</p>		<p>prevention and control training conducted by the local district health board. A record of attendance is maintained and was sighted. The training education is detailed and meets best practices and guidelines. Residents are reminded of infection control practices during residents' meetings or when required. External contact resources include GP, laboratories, and the local district health board. Training on infection prevention and Covid 19 precautions is conducted to family/whanau and residents who can still comprehend and follow basic instructions. Educational posters and leaflets distributed around the facility for visitors and families included information on Covid 19 visitors' restrictions. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. New infections and any required management plans are discussed at handover, to ensure early interventions occur. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively. Surveillance programme data is reviewed during the infection control programme periodic review. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports.</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>There were no residents using restraint or enablers on the day of the audit. There is a restraint policy in place that guides staff on the restraint and enabler use process for reference when needed. Interviewed staff demonstrated knowledge on the difference between a restraint and enabler and restraint and enabler authorisation process and monitoring requirements to ensure residents' safety. The CM is a restraint coordinator who provides support and oversight for</p>

		enabler and restraint management and demonstrated a sound understanding of the organisation's policies and procedures.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>Ten medication charts were reviewed on the electronic medication system. Administration charts demonstrate that medication is being administered as prescribed. All medication charts had been reviewed at least three monthly by the GP. All prescriptions for PRN medications document the indication for use. Seven in ten of the sample medication chart reviewed found outcomes of PRN medicines were not documented for effectiveness.</p> <p>There were no expired medications on-site, samples sighted have an issue and expiry date. Eye drops in use kept in medication trolley drawer, four in ten of sample eye drops in use had no opening dates.</p>	<p>(i) Not all outcomes of PRN medicines were documented for effectiveness.</p> <p>(ii) Eye drops in use had no opening dates.</p>	<p>(i) All outcomes of PRN medicines to be documented for effectiveness. (ii) all eye drops in use have an open date written on the eye drops bottle.</p> <p>60 days</p>

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

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

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

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

No data to display
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End of the report.