Udian Holdings Limited - Glencoe Resthome

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Udian Holdings Limited
Premises audited:	Glencoe Resthome
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 July 2017 End date: 18 July 2017

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: 14

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
	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
	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

Glencoe Rest Home is one of two facilities owned by Udian Holdings Ltd. Glencoe Rest Home provides rest home level care for up to 15 residents. There are 14 residents receiving care at the time of this audit.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, a review of residents' and staff files, observations, and interviews with residents, family members, the manager, staff, the owner/director and the general practitioner. Feedback from residents and families/whānau members was positive about the care and services provided.

The seven areas requiring improvements from the previous audit have been addressed by the service and are now fully attained. There is one new area identified for improvement from this audit related to essential notifications.

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.

The service demonstrates residents' rights to full and frank information and open disclosure principles are met. Independent interpreter services are accessible; however, family normally are used wherever necessary to ensure good lines of communication are maintained with residents.

Complaints management is well documented. All processes are undertaken to meet standard requirements. There are no open complaints at the time of audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The organisation's philosophy, mission and vision statements are identified in the business, quality and risk management plan. The manager ensures service planning covers business strategies for all aspects of service, to meet residents' needs, and good practice standards.

The quality and risk system and processes support effective, timely service delivery. Policies and procedures are developed by an external consultant. The quality management systems include a comprehensive internal audit programme, compliments, complaints management, incident/accident reporting, hazard management, resident satisfaction surveys, and restraint and infection control data collection. Quality and risk management activities and results are shared with the owner/director, staff, residents and families/whānau, as appropriate. Corrective action planning is documented.

New staff have a comprehensive orientation. Staff participate in relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Residents and families/whānau confirmed during interview that all their needs and wants were met. The service has a documented rationale for staffing. Staffing numbers, including registered nurse hours, align with contractual requirements.

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.		Standards applicable to this service fully attained.

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.

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.		Standards applicable to this service fully attained.

The facility has a current building warrant of fitness. There have been no changes required to the fire evacuation plan.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no restraints were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.

Aged care specific surveillance is undertaken, analysed and results reported and communicated to staff at the staff meetings. Follow-up action is taken 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	16	0	0	1	0	0
Criteria	0	41	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Two of 14 new residents do not have advance care plans as both residents are new to the facility and the GP is awaiting medical history. All 14 residents have established and documenting enduring power of attorney requirements. There are processes for residents who are unable to consent and evidence is defined and documented, as relevant, in the resident's record. The facility manager interviewed stated that there are no separate admission agreements for private paying residents. Two of 14 residents do not have an admission agreement signed due to current unavailability of a designated authority/NOK (one whom is currently overseas), included in this number is the private paying resident. All 14 residents have notification of appropriate level of care. Staff were observed to gain consent for day to day care. The previous audit identified two areas for improvement as all residents and family members were not informed of the use of security cameras and one resident was unable to open the external gate without assistance. Both corrective actions have now been addressed and closed. Informed consent for cameras was evidenced in the admissions agreement, general informed consent and posters throughout the facility. The external gate now has a push button release accessible to all residents. Interviews with residents and families confirmed that they were

		aware of the cameras and were able to access the external gate.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Glencoe Rest Home implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family/whānau and staff reported their understanding of the complaints process. One family member interviewed confirmed staff and managers had responded promptly to a complaint they had recently made, and all issues raised were resolved to their satisfaction. A complaints register is maintained and associated records verified. Complaints are investigated and responded to in a timely manner. The shortfall from the last audit has been addressed. Very few complaints are received. There have been no complaints received from the District Health Board, Ministry of Health or Health and Disability Commissioner since the last audit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. Residents and relatives who do not speak English are advised of the availability of an interpreter. The manager advises that family members normally speak English and prefer to be utilised for communication with the residents. The manager notes if the resident is attending health appointments offsite, independent interpreters are utilised where required. The two family members of a resident that had limited ability to communicate in English expressed satisfaction with staff and their family member's communication processes. The family noted staff understood key phrases and body language and contacted the family where applicable for assistance. The resident also indicated satisfaction with services. Three family members interviewed confirmed that they are kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes and accident/incident forms.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	Glencoe Rest Home has a documented mission statement, philosophy and values that is focused around the provision of individualised, quality care in a warm, loving environment. The manager lives on site and is confirmed being readily available to residents and family. The manager monitors the progress in achieving goals via day to day activities, resident / family feedback and monitoring of the results of quality and risk activities. The day to day operations and ensuring the wellbeing of residents is now (as of January 2016) the responsibility of the manager. The manager has worked at Glencoe since the owner / director purchased the rest home, and prior to this, has worked in a range of information technology / communication roles both in New Zealand and overseas. Prior to January 2016, the owner / director was

consumers.		responsible for services. The letter communicating the change in manager to HealthCert at the Ministry of Health was sighted. The manager participates in relevant ongoing education as required to meet the provider's contract with Counties Manukau District Health Board (CMDHB). This includes participating in the aged related care industry meetings. The shortfall from the last audit has been addressed. The owner / director was interviewed by telephone and confirmed having conversations with the manger on at least a daily basis and sooner where required and verified being fully informed of business and quality and risk issues in a timely manner. Since the last audit there has been some refurbishment of the facility. New flooring has been placed in the manager's office, kitchen and dining room. Some of the bedrooms have been repainted. This aligns with facility goals. An experienced registered nurse was employed in April 2017 who is responsible for clinical services (the clinical co-ordinator). She works 20 hours a week on site, normally Monday, Tuesday, Thursday and Fridays. The clinical coordinator (CC) is on call at all times when not on site. The CC has a current annual practising certificate (APC), and reported having just completed the ongoing interRAI competency requirements. However, in the interim another registered Nurse (RN) has been contracted to assist with interRAI assessments. The hours worked depends on the number of new residents and number of residents requiring review. This RN was interviewed and provided an overview of responsibilities including how the contracted RN obtained information on the residents for the interRAI assessment processes. The hours for interRAI assessment were additional to the employed clinical coordinator hours. The service has a contract with CMDHB for the provision of aged related long-term support, chronic health conditions and residential and respite services. There is a separate contract being negotiated (draft sighted) for a resident who is under 65 years of age with a chronic health condition. All residents have been assessed as requiring rest home level care. This includes one resident under the care of the DHB mental health services.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement	FA	Glencoe Rest Home has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, health and safety reporting, hazard management, infection control data collection and management, restraint and complaints management. Regular internal audits are conducted and demonstrated a high level of compliance with organisation policy. If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions are developed and implemented and monitored for effectiveness. Quality information is shared with all staff via shift handover as well as via the monthly staff meetings. The minutes of each meeting were available in the staff office. Staff interviewed verify they are kept well informed of relevant quality and risk information. Meetings are held every month with residents to obtain resident feedback on services, food, and activities as well as obtain information for future planning. The minutes of the 2017 meetings were sighted for residents, along with the

principles.		results of the recent resident satisfaction survey. The feedback from residents in the satisfaction survey was very positive. Policies and procedures were readily available for staff. Policies have been developed by an external consultant and one paper copy of policies is available for staff. Where amendments are made to policy, a log of changes is maintained. The clinical coordinator is responsible for document control processes. Staff, resident and family/whānau interviewed expressed a high level of satisfaction about the services provided at Glencoe Rest Home. Actual and potential risks are identified in the quality and risk plan. These were reviewed in 2017 when the 2017 annual plan / goals were documented. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard register sighted was up to date.
Standard 1.2.4: Adverse Event Reporting 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.	PA Moderate	Policy and procedure details the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as component of the ongoing education programme. Applicable events are being reported in a timely manner and also disclosed to the resident and or designated next of kin. This was verified by residents and a family member interviewed. A review of reported events including falls, bruising, skin tear and a medicine error, demonstrated that incident reports are completed, investigated and responded to in a timely manner. Changes were made to the resident's care plan where applicable or a short-term care plan developed where necessary. Staff communicated incidents and events to oncoming staff via the shift handover. A summary of events was discussed with staff at the staff meetings. Two essential notifications have not occurred. This is an area requiring improvement.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in	FA	Copies of the annual practising certificates (APCs) were sighted for the general practitioner (GP), the three other GPs who provide services in the GP's absence, and the two registered nurses (RNs). Recruitment processes includes completing an application form, conducting interviews and reference checks. Police vetting is now occurring for new staff when employed. Staff have a job description on file. The job description / employment contract includes a statement advising staff of privacy / confidentiality requirements. Annual performance appraisals have occurred in the applicable staff files sampled. New employees are required to complete an orientation programme relevant to their role. A checklist is utilised to

accordance with good employment practice and meet the requirements of legislation.		ensure all relevant topics are included. New employees are buddied with senior staff for a number of shifts until the new employee is able to safely work on their own. The shortfall from the last audit has been addressed. A staff education programme is in place with in-service education provided monthly. The topics are scheduled over a two-year period and align with Glencoe Rest Home's contract with CMDHB. Education provided in 2017 includes (but is not limited to); fire safety, abuse and neglect, emergency events, communication, professionalism, documentation, food safety, advocacy services, the Code of Rights, and cultural safety. Staff can also attend relevant external education. Records of education are maintained and copies of some education certificates are present in the staff files reviewed. Three caregivers have completed an industry approved qualification at level two, and another caregiver has a qualification with equivalency verified at level three.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider's contract with Counties Manukau District Health Board (CMDHB). The current roster was reviewed and demonstrated that there is a RN (the clinical coordinator) on duty 20 hours a week, and another contracted RN undertaking interRAI assessments and associated documentation (refer to 1.2.1.). Historic rosters were sighted in a file. The manager is on site most days and provides meal services and assists with residents' care. The manager and the RN is on call when not on site. This was verified by interview with the RN, Manager and caregivers. One caregiver works 7am to 3pm, 3pm to 12 pm, and 12 pm to 9 am. A caregiver also facilitates the activities programme with activities planned four days a week. These are undertaken when the manager or another staff member is available / present to provide oversight of residents' care. Cleaning and laundry duties are shared by caregivers over the 24 hour period. Laundry is washed on site then dried off site at a commercial laundry during the day. Linen is folded by the night caregiver. A staff member with a current first aid certificate is on duty at all times. The manager advised that additional staff hours would be allocated to meet the care needs of the residents if required. Residents and the family member interviewed confirmed their personal and other care needs are being well met.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. The previous audit identified an area for improvement to ensure that all staff administering medication were medication competent. This corrective action is now addressed and closed as evidenced in

that complies with current legislative requirements and safe practice guidelines.		documentation and interviews. The registered nurse and all care staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries. The records of temperatures for the medicine fridge were reviewed and are within the recommended range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines. There was one resident who self-administers medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. There is an implemented process for comprehensive analysis of any medication errors.
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.	FA	The food service is provided on site by the facility staff, and is 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. Recommendations made at that time have been implemented. 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 previous audit identified an area for improvement to ensure that all staff involved with food services have completed approved food safety training. This corrective action is now addressed and closed and records were available to demonstrate this. 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 resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of 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 interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is very good. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme is provided by an activity therapist. A social assessment and history is 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 resident's activity needs are evaluated six-monthly and as part of the formal six-monthly care plan review. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whanau are involved in evaluating and improving the programme through resident's meetings. Residents interviewed confirmed they find the programme interactive and meaningful.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. The previous audit identified an area for improvement to ensure that relevant information from incidents and accidents is included in the residents' evaluations. This corrective action is now addressed and closed. 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 an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting change.
Standard 1.4.2:	FA	The facility has a current building warrant of fitness with an expiry of 16 March 2018. No changes have occurred to the facility with the exception of some renovation / refurbishment activities, including new flooring in the office,

Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		kitchen and dining room. Some residents' bedrooms have been repainted. The fire evacuation plan has not required amendment.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in meetings to reduce and minimise risk and ensure residents' safety. The RN completes a monthly surveillance report. The service monitors respiratory tract infections, wounds, skin, urinary tract infections, eye infections, gastroenteritis and other infections. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff meetings, and where appropriate, to residents/family members. Additional fluids were provided to residents during summer. Residents are seen by the GP in the event an infection is suspected.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice, and the role and responsibilities. On the day of audit, no residents were using either restraints or enablers. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff and minutes of staff meetings.

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)
Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.	PA Moderate	The manager identified the type of events that must be reported to external agencies as an essential notification. Documentation including template reporting forms are present in policy manuals. It was identified during discussions that two events requiring essential notification since the previous audit have not been reported. These related to a resident who went absent without leave and this was reported to the police. The resident was subsequently safely returned to the rest home by police several hours later. The death of a resident in early 2017 was reported to the coroner. The manager advises no further information has been received from authorities related to this.	Two events that required essential notification had not been reported to the DHB or HealthCert (Ministry of Health).	Ensure all events that require reporting to the Ministry of Health, District Health Board or other governmental agencies / departments are notified in a timely manner. 90 days

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, these 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.