# Ropata Lodge Limited - Ropata Lodge

## 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:

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| **Legal entity:** | Ropata Lodge Limited |
| **Premises audited:** | Ropata Lodge |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 13 February 2018 End date: 13 February 2018 |

**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:** 10

# 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 |
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| | 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 |
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| | 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

Ropata Lodge is certified to provide rest home care for up to 34 residents. However, currently there are only ten rest home level care residents receiving services under the contract, with the other apartments occupied by residents on private rental agreements. They were not part of this audit process. The service is operated by Ropata Lodge Ltd and managed by a facility nurse manager who also takes the role of a registered nurse. A clinical nurse manager is employed for one day a week. Residents spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, management, staff, the owner and a general practitioner. No relatives were available for interview during the audit.

This audit has resulted in identified areas requiring improvements relating to planning, which was also identified in the previous certification audit, and staff training. Improvements have been made to the quality systems, risk management, long term care planning, medication management and infection control, addressing those areas requiring improvement at the previous audit.

## Consumer rights

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| 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. |

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

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

## Organisational management

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| 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. |

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with

corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. Staff have regular individual performance reviews. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

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| 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. |

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is run by an activities co-ordinator and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by senior care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for.  Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## Safe and appropriate environment

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| 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. |

There is a current building warrant of fitness.

## Restraint minimisation and safe practice

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| 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. There were no enablers or restraints in use at the time of audit

## Infection prevention and control

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| 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. |

The infection prevention and control programme, led by an appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from an external advisor and the Lower Hutt District Health Board. The programme has only recently been introduced and is to be reviewed annually.

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

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

## Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|---|---|---|---|---|---|---|---|
| **Standards** | 0 | 16 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 0 | 2 | 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) |
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| **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 |
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| Standard 1.1.13: Complaints Management<br><br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.<br><br>The complaints register reviewed showed that two complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility nurse manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with consumers and provide an environment | FA | Residents stated they were kept well informed about any changes to their status, were advised in a timely manner about any incident or accident investigations and outcomes of regular and any urgent medical reviews. Families were also kept well informed and this was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.<br><br>Staff knew how to access interpreter services. |

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| conducive to effective communication. | | |
| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Moderate | The strategic and business plans were reviewed. The documents do describe service goals and objectives and a general business strategic direction but these have not been reviewed since 2015 and 2016 respectively. The service is managed by a facility nurse manager who holds relevant qualifications and has been in the role for three and a half years. She reported there are regular meetings with the owner and she regularly reports on occupancy. However, monitoring the progress against the two plans is not occurring.<br><br>Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through her professional registration and attendance at management courses.<br><br>The service holds contracts with the DHB for residential aged care and respite care. Ten residents were receiving services under the rest home contract at the time of audit. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. A formal process is now in place to analyse data collected which then feeds into corrective action planning. This has addressed previous the shortfall identified at the last audit. Data collected includes the management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections and medication errors and health and safety.<br><br>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly quality control team meetings and staff meetings. Monthly graphs are put up in the staff areas to keep staff informed on progress around the quality indicators. Staff reported their involvement in quality and risk management activities through both audit activities and the regular staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. A process to measure achievement against the quality plan is also now formalised.<br><br>Resident and family satisfaction surveys are completed annually. The most recent survey showed general satisfaction with the services provided, however there were some comments about the time taken to act on maintenance requests. The facility nurse manager has been following up on these with the owner.<br><br>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. |

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| | | A risk register that has been now developed and monitored has also addressed a corrective action identified at the previous audit. The facility nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. She is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. |
| Standard 1.2.4: Adverse Event Reporting<br><br>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. | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the quality control team and staff.<br><br>The facility nurse manager described essential notification reporting requirements. She advised there have been no notifications of significant events made to the Ministry of Health since the previous audit. |
| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies were being consistently implemented and records maintained.<br><br>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and an oral performance review is completed after a three-month period.<br><br>Continuing education is planned on an annual basis, including most mandatory training requirements. Only four care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Two new staff are not yet enrolled to do any external study. In addition, staff attendance at internal training is poor. The annual core internal training programme does not include all the elements required.<br><br>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of all staff annual performance appraisals. |

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| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels as required using interRAI needs levels and in consultation with staff. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents interviewed supported this. Observations and review of a two-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.<br><br>Concern was expressed by the GP around the additional clinical demands on the RN, imposed by the facilities obligation to its privately funded residents. However there was no evidence sighted to verify residents' needs were being compromised by staff attending to private residents. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | 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.<br><br>A safe system for medicine management using a manual system 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. All staff who administer medicines are competent to perform the function they manage.<br><br>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.<br><br>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries, and this addresses an area identified as requiring improvement at the previous audit. The other concern previously raised around the use by dates of eye drops when opened, has also been addressed. All eye drops in use had a use by date recorded on the container.<br><br>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.<br><br>Good prescribing practices noted included 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 was consistently recorded on the electronic medicine chart.<br><br>There were no residents who were self-administering medications at the time of audit, however processes are in place to ensure this is managed in a safe manner, if residents choose to self-administer. |

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| | | Medication errors are reported to the RN/facility nurse manager and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.<br><br>Standing orders are not used. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>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 a qualified chef 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 year. Recommendations made at that time have been implemented. The menu is in the process of being reviewed again and the facility is waiting for the dietician's report.<br><br>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 cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. An A grade certificate of hygiene from the Hutt City Council, expired June-2017. An inspection has been undertaken and a new certificate is in the process of being issued, however a requirement for the facility to submit the paperwork to enable this to occur has been overlooked. This is being attended to. Registration of a food control plan has yet to be undertaken. The chefs request for chipped laminated shelving in the kitchen, a replacement splashback, and areas of chipped paint to be attended to by maintenance is waiting to be addressed (refer criterion 1.2.1.1).<br><br>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.<br><br>Evidence of resident satisfaction with meals was verified by resident interviews, satisfaction surveys and residents' meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.5: Planning<br><br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service | FA | In five of five residents' care plans reviewed, the plans reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. This finding addresses a previous area identified for improvement, whereby care plans did not always describe the required support that was identified in the assessment process. In particular, the current needs of the residents identified by the interRAI assessments were reflected in the care plans reviewed.<br><br>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented |

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| delivery. | | and verbally passed on to relevant staff. Residents reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | In files reviewed, 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. The GP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. 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<br><br>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 a recreation co-ordinator, with experience in caring for older adults. The activities co-ordinator has qualifications in providing activities to older adults, however does have an interest in art. The residents are observed to be fully engaged in the activities being provided by the activities co-ordinator.<br><br>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 residents' activity needs are evaluated regularly and as part of the formal six monthly care plan review.<br><br>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included chair exercises, visits by a beautician, visits by the hairdresser, mystery van outings, fortnightly shopping trips to the mall, entertainers, coffee club, housie, visiting pets, quiz sessions and daily news updates.<br>A facility van is available for outings. The recreation officer drives the van, however does not have an up to date first aid certificate (refer criterion 1.2.7.5).<br><br>The activities programme is discussed as part of the discussion during activity sessions and at the three monthly residents' meetings. Residents and family satisfaction surveys demonstrated satisfaction with the activities and residents interviewed confirmed they find the programme meets their needs. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service | 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.<br><br>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment |

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| delivery plans are evaluated in a comprehensive and timely manner. | | or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections and pain, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Residents interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 25 March 2018) is publicly displayed. |
| Standard 3.1: Infection control management<br><br>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. | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual. The facility nurse manager (FNM) is the designated infection control nurse, whose role and responsibilities are defined in a job description. Training has been provided and clear lines of responsibility documented. Infection control matters, including surveillance results, are reported monthly to the staff and tabled at the quality/risk meeting. Infection control statistics are collected and analysed and compared with the organisation's previous infection data.<br><br>During winter months, signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. A previous finding around the IPC, identified there was no clearly defined responsibility for IPC, no job description, no formal training and no clear lines of accountability. This has now been addressed.<br><br>The infection control programme, has not yet been implemented for a year and therefore has not yet had a formal annual review. The FNM is aware of this, and this is timetabled to occur this month. |
| Standard 3.5: Surveillance<br><br>Surveillance for | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at |

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| infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | | handover, to ensure early intervention occurs. This finding addresses a previous area requiring improvement in that there was no formal surveillance programme operating at Ropata Lodge.<br><br>There has been no norovirus outbreaks at Ropata Lodge in the past three and a half years. Any residents with potential norovirus symptoms are promptly isolated to minimise risk. Adequate supplies for outbreak management were available.<br><br>The facility nurse manager reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is recorded in the facility's infection records. Graphs are produced that identify trends for the current year, and comparisons against previous years. |
| Standard 2.1.1: Restraint minimisation<br><br>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 (the facility nurse manager) would provide support and oversight for any enabler and restraint management required in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. On the day of audit there were no restraints or enablers in use and the facility has been not used any restraint since its initial certification. |

# 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) |
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| Criterion 1.2.1.1<br>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Moderate | A Business, Quality and Risk plan was completed in 2016 which outlines the purpose, values, scope, direction and goals of the organisation. A five year strategic plan was also completed in 2015. However, these plans do not align and have not been reviewed. The owner was unaware that the Business, Quality and Risk plan was in place. No annual operational plan had been developed with the facility nurse manager to guide her in the management of the facility. The strategic plan did not have any process in place to monitor progress and there was no evidence of appropriate direction from the owner to support management and service delivery processes. This criteria was identified as an area for improvement at the last audit and has yet to be addresses. | The strategic and business/operational planning process is not being reviewed and updated regularly. There is no current operational plan. This is impacting on the identification and subsequent review of a number of previously planned actions, including some on-going maintenance issues, which have not been yet been appropriately addressed. There have been a number of maintenance issues identified in the kitchen. As planning concerns were raised at the last certification audit, they will need addressing as soon as possible to ensure some of the identified actions not yet actioned, do not become a health and safety concern. | Review and update both the strategic and business plans and put in place a current operational plan. Develop and implement a process to monitor progress against the identified goals, activity and direction of the service.<br><br>90 days |

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| Criterion 1.2.7.5<br><br>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | The annual training plan was reviewed. The policy requires a number of modules that should be completed annually but these were not all included in the 2018 training plan. While the plan did contain most of the core training requirements, there was no training in the Code or advocacy services as required annually. In addition, the record of attendances at the training showed few staff (one session only four attended) are attending the programmes provided or completing any review and follow up of core training sessions missed. Two new care staff are not yet enrolled to do any NZQA training. The activities coordinator does not have a current first aid certificate. | The annual training programme does not have all the required core modules included as per the policy. Staff are not completing the required training and attendance at the training sessions is not regular. First aid training is not current and the activities coordinator has not yet completed the first aid training required for her role. | Ensure all staff complete the relevant core training required. Review and update the annual training programme to include all the training as required in the organisation's policy and DHB contract. Provide relevant first aid training for the activities coordinator and all staff who are now due to update their training.<br><br>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 |
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End of the report.