

Te Ata Resthome Limited - Te Ata Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Te Ata Resthome Limited

Premises audited: Te Ata Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 4 April 2018 End date: 5 April 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: 28

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

Te Ata Rest Home provides rest home level care for up to 29 residents. The service is operated privately and the owner/manager (manager) oversees all aspects of service delivery with the assistance of a clinical nurse manager who is a registered nurse.

This certification 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, family members, managers, staff and a general practitioner.

This audit has resulted in three criteria gaining a continuous improvement as the service has exceeded required standards. Two of these relate to quality and risk management and one relates to cleaning and laundry service monitoring. No areas for improvement were identified.

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 Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required. An interpreter service is available.

There are no known barriers to Maori residents accessing the facility. There was one resident and four staff who identified as Maori. Services are planned to respect the individual culture, values and beliefs of the residents.

There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained. Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to formal interpreting services if required.

The service has strong linkages with a range of specialist healthcare providers which contributes to ensuring services provided to residents are of an appropriate standard. A complaints register is maintained with complaints resolved promptly and effectively.

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.	All standards applicable to this service fully attained with some standards exceeded.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the manager is undertaken monthly. Both the manager and the clinical nurse manager are experienced and suitably qualified for the roles they undertake.

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. All aspects of quality and risk are clearly documented to show trends, corrective actions if required, and evaluation processes. 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. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up-to-date, legible and relevant residents' records are maintained in integrated hard copy records.

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.
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Te Ata Rest Home works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Services are provided by suitably qualified and trained staff to meet the needs of residents. The clinical nurse manager is supported by care staff, a contracted physiotherapist, podiatrist, pharmacist and a general practitioner. Shift handovers support continuity of care.

Residents have an initial nursing assessment and short-term care plan developed by the clinical nurse manager on admission to the service. After a full assessment the person-centred care plans are developed and implemented. Short-term care plans are developed to manage any new problems or issues that might arise. All residents' records 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 the care planning process, including evaluation, and that care is provided is of a high standard. Residents are referred to other providers as required with verbal and written handovers.

The activities programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings and for attending appointments in the community.

Medicines are managed according to policies and procedures developed and implemented. Medicine administration is consistently implemented using an electronic system. Medicines 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. The service has a four-week menu planning system which has been approved by a dietitian. The kitchen was well organised, clean and meets the food safety standards. 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.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness. Cleaning and laundry services are closely monitored, and the service undertakes cleaning processes to a very high standard throughout the facility.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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 organisation has implemented policies and procedures that support a restraint free environment. No enablers or restraints were in use at the time of audit. Documentation identifies that a comprehensive assessment, approval and monitoring process with regular reviews will occur if restraint is commenced. Policy states the 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.
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The infection prevention and control programme is led by the clinical nurse manager and aims to prevent and manage infections. There are terms of reference for the infection prevention and control committee which meets quarterly. Specialist infection prevention and control advice can be accessed from the district health board, microbiologist and the general practitioner as required. The infection prevention and control programme is reviewed annually.

Staff demonstrated good principles and practice around infection control which is guided by relevant policies and procedures and supported by excellent reference material and regular education.

Aged care specific surveillance is undertaken and data is analysed and trended. The results of surveillance are reported, displayed and fed back to staff. 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	1	44	0	0	0	0	0
Criteria	3	90	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	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 in the in-service education programmes. Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, 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 residents reported that they understand their rights. The relatives reported that residents are treated with respect and dignity.
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	Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where applicable, this is activated.

		<p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. An advance directive and advance care plan are used to enable residents to choose and make decisions related to end of life care. The files reviewed had signed advance care plans that identify residents' wishes and meet legislative requirements</p> <p>Residents and family/whanau (where appropriate) are included in care decisions.</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>	FA	<p>Advocacy information is available in brochure format at the entrance to the facility. Residents and family/whanau are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The staff interviewed reported knowledge of residents' rights and advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents reported they are supported to remain in contact with the community through outings and walks. Policy includes procedures to be undertaken to assist residents to access community services and a mobility van is available. The activities programme involves linking with other aged care providers.</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>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that six minor complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans show required follow up and improvements have been made where possible. The manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been two complaints made to the Health and Disability Commissioner. One was opened in June 2016 and closed in August 2017 with no follow up required. A second complaint was made in</p>

		March 2018 and a letter stating that the HDC would not be taking any further action was sighted and the complaint was closed.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	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. Copies of the Code and other information related to rights are in the residents' rooms and displayed throughout the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families, as confirmed by interview with the clinical staff. Residents and family/whānau reported that the residents are addressed in a respectful manner that upholds their rights. Information is readily available on the Nationwide Health and Disability Advocacy Service.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of resident related information. The residents interviewed and files reviewed evidenced that the individual values and beliefs of the residents are respected. There were no concerns expressed by the residents and family/whānau about abuse or neglect. Staff interviewed reported knowledge of residents' rights and understood what to do if they suspected the resident was at risk of abuse or neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery and decision making is sought if applicable. The in-service education programme includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whānau. The service provider has an affiliation with the Ngati Arawa Tribe in Rotorua. There is one resident that identified as Maori and four staff who identified as Maori. The clinical staff reported that there are no known barriers to Maori accessing the services.

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural and/or spiritual needs of the residents are provided for in consultation with the resident and family as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The lifestyle plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Residents reported that their individual cultural needs, values and beliefs are met. Staff confirmed the need to respect the individual needs of residents.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family/whanau reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals. The service has access and support from visiting specialist nurses, palliative services and mental health teams. Residents' and relatives' satisfaction surveys evidenced overall satisfaction with the quality of the care and services provided.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of</p>

provide an environment conducive to effective communication.		<p>regular and any urgent medical reviews. 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.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to communicate effectively in English. There are communication strategies in place for residents with cognitive impairment. An interpreter service is available and accessible through the DHB as needed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly reports completed by the owner showed adequate information to monitor performance is reported including quality data, complaints management, clinical issues, health and safety, financial performance, emerging risks and issues.</p> <p>The service is managed by the owner who holds relevant qualifications and has been in the role for nine years. He is supported by an experienced registered nurse who is the clinical nurse manager (CNM) who has been in the role for eight months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Both the manager and CNM confirmed their knowledge of the sector, regulatory and reporting requirements. They maintain their currency through appropriate ongoing education, attendance at age care sector meetings with the Waikato District Health Board (WDHB) and other professional regulatory bodies.</p> <p>The service holds contracts with the WDHB for rest home level care for residents over the age of 65 years and respite care. Twenty-seven residents were receiving services under the Age Related Residential Care contract and one resident was under the Age Related Respite Care contract at the time of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service</p>	FA	<p>When the manager is absent, the CNM and the administration officer carry out all the required duties under delegated authority. During absences of the CNM the manager has two casual registered nurses</p>

is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		who will undertake the role. All staff are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.
<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>	CI	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident and family satisfaction survey, monitoring of quality improvement outcomes, clinical incidents including infections, falls, wounds and medication. Having fully attained all criteria the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of actions taken based on those findings and improvements to service provision related to resident and visitor and this has resulted in a continuous improvement rating.</p> <p>The service uses an electronic system to record and monitor all quality data. This generates a monthly self-review prompt to ensure all actions taken are evaluated. Corrective action planning is well documented, and the service can show that often they lead to a project to ensure all related issues are covered. For example, since the previous audit the facility has moved to an electronic medication system which has eliminated medication errors, they have introduced individual resident logs for infections which are clearly identified on short term care plans. All quality and risk management processes are undertaken to a very detailed level and evaluation of corrective actions are measurable.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting and staff meetings. Data is made available on the public notice board for residents and visitors to see. Staff reported their involvement in quality and risk management activities through undertaking regular audit activities, the use of quality improvement forms if they feel something can be done better and the implementation and evaluation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent surveys undertaken in July 2017 showed an 80% 'very good' and 20% 'good' satisfaction rating for families, and a 77% 'very</p>

		<p>good' and 23% 'good' satisfaction rating for residents. The only comment made related to the incorrect return of laundry. This was documented as a project under the quality improvement management system and a new labelling system and new return of laundry systems has been introduced. No residents or family raised any concerns around laundry on the days of audit. This will be evaluated in the 2018 satisfaction survey result return.</p> <p>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.</p> <p>The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The health and safety committee undertake monthly environmental audits and documentation identifies any issues found are followed up in a timely manner.</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>	FA	<p>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 firstly at the management meeting and then at the monthly staff meeting. Any corrective actions are clearly documented and a quality improvement form is completed to ensure the information is documented electronically and that the corrective action is evaluated. For example, one resident who was a high falls risk (eight falls in four months) had detailed incident forms completed, family were notified and corrective actions shown. The corrective actions included introducing the resident to the safe use of a walking frame, the use of a call mat in the bedroom and close monitoring as shown on the interRAI assessments. The evaluation shows that the resident had no falls for the three months following the corrective actions being put in place.</p>

		<p>The service is currently undertaking a project to redesign the incident accident form to capture better information, the policy and procedures have been updated to cover guidelines for post fall management, the neurological chart has been updated and whilst this has been introduced to care it is yet to be fully evaluated.</p> <p>The manager and CNM described essential notification reporting requirements, including for pressure injuries. They advised there have been two public health notifications related to outbreak management since the previous audit. There have been no notifications of significant events made to the Ministry of Health, no police investigations, no coroner's inquests and no issues-based audits since the previous audit.</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>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 are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on a biannual basis, including mandatory training requirements. This is monitored by the manager as part of the electronic quality system. 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. The CNM is a trained and competent registered nurse who maintains their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>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. The facility adjusts staffing levels to meet the changing needs of residents. Staffing levels shown on rosters</p>

		<p>exceed the required number of staff as shown on the interRAI level of care report. 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 and family interviewed supported this.</p> <p>Observations and review of eight weeks' rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All staff hold current first aid certificates.</p> <p>There are dedicated kitchen, laundry and cleaning staff. Two activity coordinators cover five days a week 9 am to 4 pm. The manager and CNM work five days a week and they are on call. The manager stated they have RN cover as required for the CNM. There is a full-time administration officer.</p> <p>The service does not use bureau staff as staff cover for each other.</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>All necessary demographic, personal, clinical and health information was completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing 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>Information is accurately entered into the assessment on Momentum (the interRAI software programme) for all residents. This includes entering other assessments results that have been clinically indicated in the comments section of the minimum data Set (MDS). The assessment summary is in all records reviewed and includes CAPS and outcome scores for each individual resident and these are addressed in the person-centred care plans reviewed.</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 admission policy includes the procedure to be followed when a resident is admitted to the home. The admission agreement contains all required information and is based on an aged care association agreement. Entry screening processes are documented and communicated to the resident and their family/whanau to ensure the</p>

		<p>service can meet the needs of the resident. The residents and family/whanau reported the admission agreement was discussed with them prior to admission and all aspects were understood. An on-line enquiry register is maintained by the clinical nurse manager and any enquiries are followed up. On admission, an entry to exit service checklist is completed by the clinical nurse manager. This documentation is a new initiative for this service.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>All residents' discharge or transfer is documented using specific forms. The service utilises the transfer forms approved by the DHB and this was confirmed in files reviewed. Known risks are identified to the place of transfer to manage the residents' safely. Expressed concerns of the resident and family/whānau are clearly documented including advance directives and enduring power of attorney (EPOA) documentation. This was confirmed in residents' files reviewed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>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, using an electronic system, was observed on the days 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 were competent to perform the functions they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The clinical nurse manager checks medications against the prescription when they are delivered. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>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 and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridges and the medication room reviewed were within the recommended range.</p> <p>The medications are prescribed through the web-based system, which</p>

		<p>includes the live update of any changed medications. The date is recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were met. The required three-monthly GP review was consistently recorded on the medicine record. There were no standing orders.</p> <p>There were no residents in the rest home who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner should this arise.</p> <p>There is an implemented process for analysis of any medication errors, with quality projects and internal audits evidencing the reduction in medication errors since the introduction of the web-based medication management system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by two cooks who share the duties during the week. One works forty hours and one works 35 hours a week. The menu follows a four-week summer and winter pattern and has been reviewed by a dietitian in the last two years. The recipes for all meals are documented on the reverse of each week's plan sighted. Any recommendations made at that time have been implemented.</p> <p>All aspects of production, preparation, storage and disposal comply with current legislation and guidelines. The cooks share the ordering of food stuffs. Food monitoring including high risk items are monitored appropriately and recorded as part of the food service planning. The two cooks have completed food handling and other relevant food handling training. A residents' food satisfaction survey was completed, and this showed that meals were appreciated by the residents. This was also supported when interviewing residents.</p> <p>A nutritional assessment is undertaken for each individual resident on admission by the clinical nurse manager. A copy is provided to the kitchen staff. Any special diets, likes and dislikes are catered for.</p> <p>There is sufficient staff on duty in the dining room at meal times to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local Needs Assessment and Service Coordination (NASC) is advised to ensure</p>

to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		<p>the prospective resident and family are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. The clinical nurse manager reported that they refer residents to different levels/types of care if they are unable to support the resident (such as psychogeriatric or secure dementia care).</p> <p>There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial assessment, which includes assessment of the residents' health and personal care needs, is completed on the day of admission. The clinical nurse manager utilised standardised risk assessment tools for the initial and ongoing assessments. The interRAI, along with other paper-based assessments, information gained from the resident and their family/whānau, referral information, observations and examinations carried out are used as a basis for developing the long-term lifestyle plan. The residents and family/whānau expressed satisfaction with the support provided and confirmed their involvement in the assessment process. The CNM ensures all interRAI assessments are completed for all residents'.</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>In all files sampled, evidence was sighted of interventions related to the desired outcomes. Risks identified on admission are included in the person-centred care plan and these included falls risk, pressure area risk and pain management. The assessment outcomes from the interRAI assessment process were included to update the person-centred care plans sighted. The clinical nurse manager reported care plans are discussed with the care staff at handover.</p> <p>All health professionals document in the resident's individual clinical file and have access to the care plans and progress notes as part of the integrated file system. Documentation in files reviewed included nursing notes, medical reviews and hospital correspondence. The residents reported that they are included in the care planning and are aware of any changes and these are discussed with them. Care staff</p>

		verified that they are informed of any changes to the plans at shift changeover. The residents reported satisfaction with the care provided.
<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>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 service provision.</p> <p>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.</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>	FA	<p>The diversional therapist and activities coordinator plan activities to meet the resident's abilities. Information gained by an activities assessment and resident's history assessment is used when developing the activity plan. There are planned activities that cover physical, social, recreational and emotional needs of the residents. The activities programme is an evolving plan to match weather conditions and residents' abilities.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered.</p> <p>Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All the files sampled had person centred care plans that have been developed and reviewed within the last six months. Formal review was in accordance with Te Ata's interRAI review schedule and residents' care and review schedules sighted. None of these files sampled were due for the six-monthly evaluations. The interRAI assessment tool outcome scores were on the files sampled. The service has processes in place to use the built-in evaluation scores when the service reassesses the resident using the interRAI assessment, and records this on their own paper-based evaluation record.</p> <p>When there are changes in the resident's needs, the service changes</p>

		<p>the person-centred care plan to capture these changes. The care plans identify the need, interventions and evaluation of the interventions. There are also additional short-term plans, such as wound treatment, falls and falls minimisation plans, which capture any short-term changes. Wounds are evaluated at each dressing change and at least weekly by the clinical nurse manager. If the issue then becomes a long-term need, this was then recorded and updated on the person's care plan. Any changes to the care plans are reviewed by the clinical team (general practitioner, caregivers, clinical nurse manager and the physiotherapist).</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>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to radiology, health screening, and medical/surgical specialists. There are several specialists/health providers that also conduct visits to Te Ata Rest Home, such as audiologists, podiatrists and dietitians. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff education occurs related to safe chemical handling. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide monthly monitoring of titration levels to show that the correct amount of chemicals is used for laundry and kitchen processes. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness - expiry date 17 June 2018, is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of biomedical equipment was current as confirmed in documentation reviewed, an interview with the manager and observation of the environment. The environment was hazard free, residents are safe and independence is promoted. The monthly environmental audits carried out by the health and safety team were sighted and they cover all aspects of legislation and ensuring there is a well maintained and comfortable environment for residents. If any deficits are found, a corrective action is undertaken and this is processed as part of the quality and risk management process. For example, one electric fan was not working so it was removed from the floor.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. An improvement has been made to the outdoor areas available to residents by the erecting of an 'Archgola' roof which allows residents to use an extended outdoor area throughout the year as they are protected from the weather.</p> <p>Residents confirmed the environment is well maintained and that all their needs are met which includes being able to have their own comfortable chair from home. Residents were sighted using the outdoor areas throughout the audit.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes eight bedrooms with ensuite toilet facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. A separate staff and visitor toilet area is available downstairs.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are six shared bedrooms; five have two beds and one has three beds. There are</p>

appropriate to the consumer group and setting.		<p>privacy curtains to maintain visual privacy. Where rooms are shared approval has been sought. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. 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>	FA	<p>Laundry is undertaken on site in a dedicated laundry which is under renovation at the time of audit. It remains usable and all required signs are displayed by the contractors working on site. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There are two designated cleaning staff who have received appropriate training. Cleaning and laundry staff have completed safe chemical handling as confirmed during interview and in staff file education records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through regular audits and by the chemical provider. Monitoring of the cleaning services is undertaken to a high level. The service undertakes monthly swabs from various areas and these are sent to the laboratory to test for environmental cleanliness. Corrective actions are put in place as required.</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>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the</p>

		<p>New Zealand Fire Service on 10 October 2007. No changes have been made to the facility footprint since this time. A trial evacuation takes place under fire service supervision six-monthly. The most recent being in October 2017 with the next one being booked for April 2018. No follow up actions were required. The facility has replaced the sashes which fire wardens used to wear with high visibility vests. The manager stated this makes them easier to recognise.</p> <p>The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, and gas BBQ's were sighted and meet the requirements for the 29 residents. Emergency lighting is tested monthly as part of the building warrant of fitness requirements as confirmed in documentation sighted.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time by the afternoon staff as part of their everyday duties.</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 and opening windows. Gas heating is provided throughout the facility and residents can have additional electric heaters in their rooms. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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 clinical nurse manager is the infection prevention and control coordinator. There is a job description that outlines the role and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meetings and the combined infection control/quality/safety committee meetings. The quality/health and safety committee reviews the monthly quality, risk and infection control issues. The clinical nurse manager collates an annual report. The December 2017 report was reviewed. The programme reviews the</p>

		<p>effectiveness of the infection control programme, education, surveillance and equipment.</p> <p>There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise relatives not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. Staff demonstrated good knowledge and application of infection prevention and control principles.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator /CNM implements the infection control programme, with support from all staff. The infection control coordinator is supported by one staff member from the laundry, kitchen and a caregiver. Infection control matters are discussed at the monthly meeting. If the infection control coordinator requires additional advice or support regarding infection prevention and control they can access this through the DHB and GP.</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 control policies and procedures have been developed by an external infection prevention and control advisory service and reflect current accepted good practice. The service has access to good practice resources from this specialist infection prevention specialist, as well as the DHB infection control specialists. The policies are appropriate to the services offered by the facility and reviewed by the national support office. The infection outbreak policy has been developed and implemented and an outbreak folder is also newly implemented. This followed two outbreaks, both reported in June and October 2017.</p> <p>Staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions per the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>There is a designated infection control coordinator who is an experienced nurse (the CNM). The organisation is a member of an external infection control advisory service which provides reference manuals to guide staff on all aspects of infection prevention and control. Flip charts are also available. There are online learning</p>

		<p>modules that are part of the mandatory education programme on infection prevention and control. The infection control coordinator has attended ongoing education related to infection prevention and control to maintain knowledge of good practice. Records are maintained of all infection and prevention education sessions by the coordinator.</p> <p>As required, infection control education is conducted informally with residents, such as reinforcement of infection control practices during an outbreak. Hand hygiene is taught at every opportunity for staff and residents.</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>	FA	<p>The service uses standardised definitions applicable to aged care that are provided by the external benchmarking service to identify infections. The type of surveillance undertaken is appropriate to the aged care service with data collected on urinary tract infections, influenza, skin infections and respiratory tract infections. There is monthly collection and collation of the types and numbers of infections in the rest home.</p> <p>The data and reporting of the statistics and analysis is provided to the manager. The outcomes are fed back to the staff at the next staff meeting. The infection surveillance records included the review and analysis of the data. With an increase in the number of urinary tract infections, the service implemented actions to reduce the recurrence of spread of the infections.</p> <p>The service had two outbreaks of norovirus in June and October 2017. Learning and actions were implemented after this event occurred.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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 should it be required and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities as restraint coordinator.</p> <p>On the day of audit, the facility was restraint free and no residents were using enablers. Policy states that enablers are the least restrictive and used voluntarily at their request.</p>

		Management stated that restraint is used as a last resort when all alternatives have been explored.
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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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	<p>Quality improvement data are collected, analysed and evaluated. The results are shared with staff, residents and family. Monthly electronic self-review prompts of any quality improvement put in place are reviewed by the manager and the outcomes are evaluated by the management team to ensure they have improved service delivery or resident satisfaction. The data collected includes audit results, infections, falls, environmental issues, health and safety matters. Outcomes are also measured to ensure all regulatory updates are met. For example, the training and implementation of a dedicated health and safety committee to meet current health and safety legislation.</p> <p>Staff are very involved in the quality and risk management system and during interview could verbalise how data results are measured and</p>	<p>Quality data results are used to generate quality improvements in all areas of the service. This covers both clinical and non-clinical areas. All actions are evaluated and not closed off by the manager unless an improvement has been made. If the first actions taken are not seen to be working the process is reviewed at staff meetings and something new will be trialled until the improvement is complete. Information is shared with all providers and quality data results are posted on the public meeting board for everyone to view.</p>

		responded to via corrective action planning. One example reported related to the laundry review and how the implementation of the new procedures and new equipment provided (new double linen bag holders) has improved the work flow for caregivers and laundry staff. The labelling of resident equipment means correct laundry is returned to each resident.	
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>The process the service has in place to measure achievement against the quality and risk management plan includes an electronic self-review prompt to ensure all processes are being met. The clinical indicators related to falls, incidents and accidents, medication, behaviour that challenges, care planning medication management, weight loss, complaints, education, resident movement, pressure injuries, continence, and health and safety, including hazard management, are reported against monthly and trended results are graphed. This data is linked to business planning and helps to set annual goals. For example, in the previous audit it was identified that medication management required improvement. A project was undertaken to research, trial and implement an electronic medication system to improve medication safety. This process is completed and the evaluation shows that no medication errors have occurred since the implementation of the electronic system. Staff confirmed that education was put in place prior to the implementation of the system and that part of the evaluation process included staff feedback to management. This included GP involvement.</p>	<p>A monthly printout reminds management of the actions required each month. This is only removed once all identified measures have been completed for the month. The electronic trail shows how each action is related to the quality and risk management processes in place, the actions taken, the date implemented and the evaluation of the outcome following the implementation of the action.</p>
Criterion 1.4.6.2	CI	The policies and procedures guide staff in the	The service provided laboratory evidence that

<p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>		<p>methods, frequency and materials used for cleaning and laundry. Laundry is monitored by the chemical provider to ensure the correct titrate is occurring according to each wash cycle.</p> <p>Having fully attained all criterion the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of actions taken based on those findings and improvements to service provision related to resident and visitor safety and satisfaction as a result of the review process. A daily cleaning checklist is completed by cleaning staff and this is reviewed weekly by the manager. The service undertakes environmental swabbing monthly. This occurs on random surfaces and the swabs are sent to an off-site laboratory. The results are sent to the manager and if the result is not optimal then corrective actions are put in place and the same area is re-swabbed one month later. One example related to a test from one of the bathroom floors which showed some contamination. The cleaning regime was changed to ensure that bathroom floors remain contaminant free and the frequency of washing the floors has been increased. Follow-up testing gained an optimal result. This was also the case for the iPad used in the kitchen. Staff interviewed confirmed their awareness of this process and the corrective action outcomes.</p>	<p>monthly environmental swabbing is undertaken to ensure cleaning is of a high standard and that the environment is safe for residents, visitors and staff. Documentation sighted shows that when a result comes back as being marginal, corrective actions are put in place, staff are informed and the area is re-checked one month later.</p>
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End of the report.