

# The Wood Lifecare (2007) Limited - The Wood Lifecare

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## 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	The Wood Lifecare (2007) Limited
<b>Premises audited:</b>	The Wood Lifecare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 14 March 2018 End date: 15 March 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	78

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

The Wood Lifecare is part of the Arvida group of residential aged care facilities and provides hospital (geriatric and medical) and rest home level care for up to 114 residents. On the day of the audit, there were 78 residents. The facility is managed by a village manager who is supported by a clinical manager and two clinical nurse leaders. Residents and families interviewed commented positively on the standard of care and services provided at The Wood Lifecare.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and general practitioner.

Four of the four shortfalls identified as part of the previous certification audit have been addressed. These were around informed consent, neurological observations, interRAI assessments and care plan interventions.

This audit identified further improvements are required around mandatory training and medication documentation.

## 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 service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Residents/relatives have the opportunity to feedback on service delivery through an annual satisfaction survey and open-door communication with management. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There is a business plan with goals for the service that has been regularly reviewed. Meetings are held to discuss quality and risk management processes. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed. Residents/family meetings are held regularly, and residents and families are surveyed annually. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is an annual in-service training calendar schedule. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Since the previous audit, the service has implemented an electronic recording system for client records. All resident related documents were maintained in the electronic records, except the medication management system which is paper based. Registered nurses are responsible for care plan development with input from residents and family. Service delivery plans and evaluations were completed in timely manner and they are consistent with residents' assessed needs. An activities programme is implemented by two diversional therapists who are supported by volunteers. The programme includes a diversity of activities and involvement with the wider community. Registered nurses, enrolled nurses and medicine competent caregivers administer medications and medicine reviews occur every three months. Meals are cooked on-site. Menus are reviewed by a registered dietitian. Any special dietary requirements and need for feeding assistance or modified equipment are recorded and being met. Arvida completed an organisation wide food control plan registration in June 2017. Internal food safety audits are completed.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a current building warrant of fitness.

## 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 Wood Lifecare has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. One resident was requiring a restraint and eleven residents were using enablers. A clinical nurse leader is the designated restraint coordinator.

## 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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Surveillance of infections occurs. Results of surveillance are acted upon, evaluated and reported to relevant staff, contractors, residents and visitors in a timely manner.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	2	0	0	0
<b>Criteria</b>	0	39	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service uses an electronic resident management system. All previous consent forms have been scanned and recorded in the new system. Six resident files (three rest home and three hospital) were reviewed. All files had current informed consent and advance directives records and they were completed appropriately including resident's resuscitation status. Communication related to these were recorded in the medical notes by a general practitioner (GP) and/or progress notes by registered nurses (RNs). Therefore, this finding from the previous audit has been addressed.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	FA	<p>There is a complaints procedure and the complaints process is explained in the service information provided to all residents and families on admission. A record of all complaints, both verbal and written is maintained by the village manager using a complaints' register. There have been eight complaints (all in 2017) made since the last audit. A review of the complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered, and all letters include a request for the complainant to comment if they are happy with the resolution. Residents and family members advised that they are aware of the complaints procedure. Family</p>



understood, respected, and upheld.		members stated that the service is responsive to complaints and manages them quickly and well. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Nine residents (seven rest home and two hospital) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. Residents/relatives have the opportunity to feedback on service delivery through an annual satisfaction survey and open-door communication with management. Two monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted). Ten accident/incident forms reviewed evidenced relatives are informed of any changes to residents' health status. Five relatives (two rest home and three hospital) interviewed, confirmed that they are notified promptly of any changes to residents' health status. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.</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 Wood Lifecare is owned and operated by the Arvida Group. The service provides care for up to 114 residents across 30 rest home beds, 46 hospital level beds and 38 serviced apartments certified to provide rest home level care. On the day of the audit there were 78 residents in total; 33 rest home residents including one younger persons with disabilities (YPD) and one resident on respite, 37 hospital residents including one YPD resident and one resident on respite. There are 13 dual-purpose beds in the hospital area for either rest home or hospital level. There were eight rest home residents in the serviced apartments. All other residents were admitted under the aged related residential care (ARRC) contract.</p> <p>The village manager has been in the role since May 2017. He is supported by a clinical manager who has been in the position for one year and two clinical nurse leaders. The village manager and clinical manager are supported by the general manager operations, general manager wellness and a national quality manager (who was available during the audit). The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report.</p> <p>Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. The Wood Lifecare has a business plan for 2017–2018. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually. Regular meetings are held between the village manager and head office as well as weekly meetings between the village manager, clinical manager and clinical nurse leaders.</p> <p>The village manager has completed in excess of eight hours of professional development in the past 12 months.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a 2018 business plan that includes quality goals and risk management plans for The Wood Lifecare. Arvida group head office sends new/updated policies which are reviewed at least every two years across the group. The village manager is responsible for providing oversight of the quality and risk management programme on-site, which monitors contractual and standards compliance and analyses trends and opportunities for improvement. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. Areas of non-compliance identified through quality activities and internal audits are actioned for improvement. Staff interviewed could describe the quality programme corrective action process. Restraint and enabler use is reviewed within the quality and clinical meetings.</p> <p>Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the Health and Safety Committee. The Health and Safety Committee has been recently changed to have more representative membership. Hazard identification forms and a hazard register are in place. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The May 2017 resident relative survey overall result shows satisfaction with services provided. The results for the resident/relative satisfaction survey completed in February 2018 have not yet been evaluated. Resident/family meetings occur bi-monthly and resident and families interviewed confirmed this. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The service continues to manage the adverse event reporting process well. There is an accidents and incidents reporting policy. Incidents and accidents are logged onto a computer software system and a monthly report, including analysis, is presented to monthly staff/quality meetings, health and safety and RN meetings. Ten resident related incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for four (one rest home and three hospital residents) reviewed unwitnessed falls with potential head injury. This previous finding has now been addressed.</p> <p>Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications made since the last audit. A gastro outbreak in February 2018 was notified to the public health authorities.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires relevant checks are completed to validate the individual's qualifications, experience and veracity. Six staff files were reviewed (one clinical nurse leader, one RN, three caregivers and one diversional therapist). There is evidence that reference checks were completed before employment was offered. There was documented evidence that annual staff appraisals were completed and up-to-date. A copy of practising certificates is kept.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme. There is an annual in-service training calendar schedule, however, there was no documented evidence of eight hours annual training being completed for all care staff in 2017. Discussion with the caregivers confirmed that monthly in-service training was not consistently completed in 2017. There are twelve RNs and six have completed interRAI training. InterRAI assessments and contractual obligations were being met (link 1.3.3). This previous finding has now been addressed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The Wood Lifecare policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 94 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager and clinical manager work 40 hours per week from Monday to Friday and are available on call after hours. In addition to the village manager and clinical manager there are two clinical nurse leaders. There is at least one RN on at any one time. The RN on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirm there are sufficient staff to meet the needs of residents. The caregivers interviewed stated that they have sufficient staffing levels.</p> <p>In the hospital area (37 hospital residents and three rest home residents), there is one clinical nurse leader and one RN on duty on the morning shift, one RN on the afternoon shift, and night shift. They are supported by nine caregivers (four long and five short shifts) on the morning shift, seven caregivers (three long and four short shifts) on the afternoon shift and two caregivers on the night shift.</p> <p>In the rest home area (30 rest home residents), there is one clinical nurse leader and one RN/EN on duty on the morning shift and one RN/EN on the afternoon shift. They are supported by three caregivers (two long and one short shifts) on the morning shift, two caregivers (one long and one short shifts) on the afternoon shift and two caregivers on the night shift. The serviced apartments (eight rest home residents) have a separate roster with two caregivers on duty on the morning shift and one caregiver on duty on the afternoon shift. The rest home staff supervise the rest home level care residents in serviced apartments after 9.30 pm.</p>
<p>Standard 1.3.12:</p>	<p>PA Low</p>	<p>The service utilises a paper-based medication management system and individualised medication packs were used</p>

<p>Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>in delivery of medicines. RNs, enrolled nurses and medicine competent caregivers administer medications. All staff that administer medicines were competent and have received medication management training. Enrolled nurses and caregivers administer medication under the direction and delegation of a RN.</p> <p>The self-administration documentation was correctly recorded, and a competency assessment was completed. One rest home and one hospital resident administer their own inhalers, and these were monitored and recorded. Medication fridge temperatures were being recorded and kept within required temperature. Thirteen medication charts were reviewed (six rest home and seven hospital). On nine occasions, signing sheets were not signed to confirm that medicines were not administered or reason for not administering medicines was not recorded.</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>All meals at the Wood Life Care are prepared and cooked on-site. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. All files reviewed had up-to-date nutritional profiles and these were reviewed at least six monthly or as required. There is a four-weekly rotating seasonal menu which has been reviewed on 27 December 2017 by the Arvida Group registered dietitian. The dietitian review was completed following changes on the meal times. Since then dinner meals were served at lunch time and light meals were offered at tea time. This was completed following requests from the residents.</p> <p>Staff were observed assisting residents with their lunch time meals and drinks. Weights were monitored monthly or more frequently if required, and as directed by the GP. The kitchen staff have completed food safety training. The temperatures of refrigerators, freezers and cooked foods were monitored and recorded. There is special equipment available for residents if required. All food was stored appropriately. Residents and family members interviewed indicated satisfaction with the food service. The Wood undertook the MPI external Food Control Plan audit on April 9, which the Arvida Dietitian attended.</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>The previous audit identified an issue around lack of detailed information in the care plan interventions to safely guide staff in service delivery. Review of six files included sufficient evidence that this corrective action has been addressed. All six files reviewed demonstrated that residents care plan interventions were individualised, and interventions were comprehensive. Care plan interventions were linked to risks identified in the interRAI assessments and interventions were reflective of resident's needs over the 24-hour timeframe in relation to clinical, nursing, nutritional, recreational, social, and psychological and night care needs.</p> <p>Files reviewed included residents with use of enabler, weight loss, memory loss, challenging behaviour, different ethnic background, diabetes and palliative care needs. All these files had appropriate intervention documented in sufficient detail to guide care staff in the provision of care. Progress towards desired outcomes or identified goals were monitored daily, weekly or longer periods as identified in the resident's file. Four caregivers interviewed confirmed that care plan interventions were well described and easy to follow. They stated that workloads in the</p>

		<p>electronic records keep them up-to-date with current changes in resident's care needs. Written and verbal handover occurs between shifts.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Resident and family interviews confirmed that all aspects of resident's care were delivered in a safe and respectful manner. Care plans were up-to-date, and interventions were comprehensive. Progress notes were written by the RNs and caregivers completed worklogs created by the RNs based on the resident's assessed needs and care plan interventions. Caregivers were observed providing care to residents, for example, transfers, repositioning, walking and supporting nutritional needs. These were reflective of the resident's care plan. General practitioner notes reviewed were comprehensive and integrated in the resident's electronic records. Required follow-up after GP visits were completed by the RNs and these were recorded in the resident's notes. Referrals to other health services occur and consequently their recommendations were followed up. Interviews with two RNs, the clinical manager, two clinical nurse leaders, the cook, two DTs and four caregivers demonstrated an understanding of the individualised needs of residents.</p> <p>Staff have access to sufficient medical supplies. Continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management plans were in place for 13 residents in the hospital and seven residents in the rest home. All wounds have been reviewed at appropriate times. The RNs have access to specialist nursing wound care management advice through the district nursing service. There was one resident with stage 1 and one resident with stage 2 pressure injury. There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</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>Individual diversional therapy plans were developed by two DTs and these were based on assessment of residents' current interest and past activities with input from the resident and their family members. These plans were reviewed at least six monthly to ensure they remain current. InterRAI assessment outcomes were used in review and development of diversional therapy plans. Sampled plans reviewed were detailed and included goals and interventions that are individualised and reflective of realistic outcomes. Activities reflect ordinary patterns of life and included individual, group and community activities. Family and friends were welcomed to attend all activities. Two DTs are supported by a number of volunteers. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. The diversional therapists review the social profile and the diversional therapy plan when the care plan is evaluated and if a further interRAI assessment occurs.</p> <p>The diversional therapy programme continues to show the opportunities for community engagements such as regular visits from the local primary school, the local pre-school and an English language school. Special activities are implemented for the men's group. These include monthly meetings, BBQ's and fishing club. There are weekly</p>

		walks to the town and monthly outings with a wheelchair accessible van. Swimming at the local pool is organised fortnightly and the DT reports at least six residents regularly participate. Staff, volunteers, and family members support these community activities. A DT interviewed, reported that feedback is sought from residents during and after activities and through residents' and family feedings. The residents and families interviewed spoke very highly of the activities programme.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Review of six files identified that care plans were evaluated initially within three weeks of admission and thereafter at least six monthly. This was evident in four out of six files. One file was related to a resident residing at the facility less than six months and the second file was respite care. More frequent evaluations were sighted where progress is different from expected. Consequently, the RN responded by initiating changes to the care plan using appropriate assessment tools. The RN also creates worklogs for the caregivers to monitor and document progress against identified interventions. Using this information, short-term care plans were reviewed daily, weekly or fortnightly according to the degree of risk identified.</p> <p>InterRAI assessments were completed at least six monthly or after significant change. Short-term care plans reviewed were indicative of the residents' current changed needs. There was at least a three-monthly review by the GP and all changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Resident and family interviews confirmed that they were included and informed of all care plan updates and changes. Four caregivers interviewed demonstrated knowledge in following short-term care plans when needs change.</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>	FA	The building has a current building warrant of fitness that expires on 4 August 2018.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out</p>	FA	The infection control (IC) programme is implemented, and surveillance of infections occurs. The IC nurse collects data on all infections daily and develops a monthly report of all infections. Results of surveillance activities were acted upon, evaluated and communicated to staff, and as appropriate relevant contractors, residents and visitors in a timely manner. Specific trends were identified, and recommendations were implemented. Short-term care plans

<p>in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>were used for individual infections. Reports are easily accessible to the village manager, clinical manager and head office staff. There had been a gastro outbreak in February 2018 and there were seven cases including two staff members. Review of documentation showed that it was well managed, and consequently the public health authorities were notified.</p>
<p>Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. There was one resident with restraint (lap belt) and eleven residents with enablers (all bed rails). Review of restraint usage and all restraint and enablers are reviewed monthly. Residents' files for residents with enablers showed that enabler use is voluntary. One restraint file and three enablers files all included appropriate assessment, consents and monitoring.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There is an annual in-service training calendar schedule, however, there was no documented evidence of eight hours annual training being completed for all care staff in 2017. Discussion with the caregivers confirmed that monthly in-service training was not consistently completed in 2017. Not all compulsory two-yearly education has been completed. Several competencies are completed by staff.</p>	<p>Not all compulsory education has been completed within the last two-years.</p>	<p>care staff. Ensure that the annual education planner is fully implemented, and education is provided to include all contractual requirements.</p> <p>90 days</p>



<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>The service uses paper-based documents in medicine management. The resident's prescription medication records were completed by the resident's GP and these records were legible and signed individually by the GP including when discontinued. Registered nurses check medicines on arrival from the pharmacy and any discrepancies reported back to the supplying pharmacy. Two RNs were observed administering medications correctly in both areas. 'As required' medication was reviewed by a RN each time prior to administration. Thirteen medication charts reviewed revealed several signing gaps.</p>	<p>In three hospital and one rest home chart reviewed, medication signing sheets had several signing gaps showing either medicines were not administered, or reason for medication not given was not recorded. These missing signatures were in nine occasions.</p>	<p>Ensure that medications are signed as administered or reason for 'not given medication' documented.</p> <p>60 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.