Experion Care NZ Limited - Wensley House

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:	Experion Care NZ Limited
Premises audited:	Wensley House
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 May 2018 End date: 16 May 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: 31

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

Wensley House provides rest home level care for up to 44 residents. The service is operated by Experion Care NZ Limited and managed by a general manager and a clinical nurse leader. Residents and families spoke positively about the care provided.

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, management, staff and a general practitioner.

This audit has resulted in 15 areas requiring improvements relating to quality and risk management, staff training, care planning, medication management, integrity of some wall surfaces, documentation of the evacuation plan and infection control management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

The 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.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was 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 confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

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

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 governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection of some data but has not yet been fully implemented to provide analysis of quality improvement data and trends. Adverse events are documented with some corrective actions implemented. Actual and potential risks, including health and safety risks, are identified. Policies and procedures to support service delivery 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 is in the early stages of development for the organisation. 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, and relevant residents' records are maintained in a mix of hard copy and electronic files.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The organisation 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.

Residents' needs are assessed on admission within the required timeframes. Shift handovers guide continuity of care.

Care plans are individualised, based on a range of information. Short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being well informed and involved in care planning, and that the care provided is good. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and a recreation officer and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed using a manual system. The integration of an electronic system is nearing the implementation stage. Medications are administered by registered nurses and care staff.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised and clean. Residents verified overall 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.		Some standards applicable to this service partially attained and of low risk.

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.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers nor restraints were in use at the time of audit. 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The infection prevention and control programme, led by an infection control co-ordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from an external advisory service. Staff demonstrated good principles and practice around infection control.

Aged care specific infection surveillance is undertaken and data analysed.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	36	0	2	2	5	0
Criteria	0	78	0	4	5	6	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	Wensley House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.

		Staff were observed to gain consent for day to day care on an ongoing basis.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at the entrance to the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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. The complaints register reviewed showed that two complaints have been received since June 2017 (new ownership date) and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The general manager (GM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback

		forms.
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	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room. Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.
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	There are no residents in Wensley House at the time of audit who identify as Māori, however interviews verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisors accessed through the Nelson Marlborough District Health Board (NMDHB).
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic,	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living.

cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals for example, external infection control specialist/advisors, district nursing service, hospice/palliative care team, occupational therapist and the clinical nurse specialist (CNS) from NMDHB. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Registered nurses (RNs) reported they receive management support to attend external education at the NMDHB.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via NMDHB and Interpreting New Zealand when required. Staff reported interpreter services were rarely required due to all present residents being able to speak English.
Standard 1.2.1: Governance	FA	The strategic and business plans, which are reviewed annually, outline the purpose, values,

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A sample of quarterly reports to the board of owners showed information to monitor performance is reported including financial performance, emerging risks and issues, occupancy and staffing issues. Quality data has yet to be included in reporting information. The service is managed by a GM who holds relevant qualifications and has been in the role since June 2017. The GM is a registered nurse and has a business degree. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The GM confirmed knowledge of the sector, regulatory and reporting requirements and has previously been in a management role, within the health sector, but not aged care. The service holds contracts with the DHB, MoH for younger persons with a disability (YPD), respite and rest home level medical conditions. Thirty-one residents were receiving services under the DHB residential care contract at the time of audit.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	When the GM is absent, the clinical lead carries out all the required duties under delegated authority (this has not yet occurred as the GM has not yet taken leave). During absences of key clinical staff, the clinical management is overseen by a registered nurse or the GM who is experienced in the sector and able to take responsibility for any clinical issues that may arise, or the owner may utilise experience clinical staff from one of his other facilities.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA High	The organisation has a planned quality and risk system recently developed; however, not all systems are in place. Documentation to support management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, is available but has not been imbedded as staff did not have access to the associated documentation until the days of audit. Meeting minutes reviewed confirmed related information is reported and discussed at the health and safety, quality team and staff meetings. However, not all key components of service delivery are included as agenda items at these meetings or analysed and evaluated. Staff report they are not aware of quality and risk management activities or the facility's current policies as these are in an electronic format. Corrective actions have been partially developed to address accidents; however, not all were completed or closed out. Resident and family satisfaction surveys have not been completed

		since the new ownership and management have been in place. Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies sighted are based on best practice and were current. The electronic document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. On the days of audit, the GM printed all policies and placed in folders for staff to access. The GM 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.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	Staff document adverse events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed regarding the accident/incident, an investigation has occurred, an action identified, but not always completed. Adverse event data is not always collated, analysed and reported to the quality and staff meeting (refer criterion 1.2.3.6). The GM described essential notification reporting requirements, including for pressure injuries. They advised there have been two notifications of significant events made to the Ministry of Health since the previous audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA High	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 not consistently implemented. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them for their role. Staff records reviewed showed documentation of completed orientation in most files reviewed. Continuing education is planned on an annual basis; however, this has not included mandatory training requirements. Care staff have either completed or have commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are two trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI

		assessments. Records reviewed demonstrated not all staff have completed the required training and annual performance appraisals have not been undertaken in 2017/18 year.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. 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. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable. 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.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facilities general manager (GM) or the clinical nurse leader. They are also provided with written information about the service and the admission process. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in

		accordance with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the facilities transfer forms to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA High	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 manual system for medicine management was observed on the day of audit. The service is in the process of implementing an electronic system. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are however not assessed as competent to perform the function they manage (refer criterion 1.2.7.5). Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are not consistently checked by a RN against the prescription. All medications sighted were within current use by dates; however, there is no system in place to ensure eye drops are discarded following their use by dates. Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration; however, two staff do not observe the medication to be taken by the right resident. The controlled drug register did not provide evidence of weekly stock checks. Entries sighted were accurate. The records of temperatures for the medicine fridge and the medication room reviewed were outside the recommended range, with no evidence of action taken to address these high temperature recordings. No refrigerated medications were observed to be compromised by this finding. A resident on Warfarin has no GP generated medication chart for care givers to access.

		Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart. Several faxed copies of medication charts are being used, with no process in place to ensure the original is updated. There was one resident who self-administers inhaler medications at the time of audit. There are no documented processes in place to ensure this is managed in a safe manner. No incidents of medication errors were sighted (refer criterion 1.2.3.5 and 1.2.3.8). Standing orders are used and authorised individually for each resident.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low	The food service is provided on site by a cook. The menu follows summer and winter patterns. It has not been reviewed by a qualified dietitian within the last two years. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken a safe food handling qualification. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews, and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. There is a cleaning schedule in place. There was no evidence of compliance with the schedule since October 2017. The kitchen was observed to be clean and tidy. A food control plan is in the process of being implemented through the organisation's national body in consultation with Ministry of Primary Industries (MPI).
Standard 1.3.2: Declining Referral/Entry To	FA	If a referral is received, but the prospective resident does not meet the entry criteria or there is

Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. 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. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	On admission, residents of Wensley House are initially assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity and nutritional screening to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require. In all files reviewed, initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments were completed within three weeks of admission and at least six-monthly unless the resident's condition changes. Interviews, documentation and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels. All residents have current interRAI assessments completed by the GM, who is a trained interRAI assessor. Evidence verifies the clinical nurse leader who is also trained in interRAI does not undertake interRAI assessments. A third RN is enrolled to undertake interRAI training. Assessment data is not consistently used to inform the interRAI care plan (refer criterion 1.3.5.2)
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA High	A review of eight residents care plans identified seven of eight resident files have an initial care plan developed on admission to guide staff in the management of resident care prior to the development of a long-term care plan. One of eight files had no initial care plan in place to guide staff in meeting the resident's required needs. Eight of eight plans reviewed did not fully reflect the required support needs of the residents, the outcomes of the integrated assessment process and other relevant clinical information, particularly those needs identified by the assessment findings. Any change in care required was documented in progress notes and verbally passed on to relevant staff. Care plans however, did not evidence integration with progress notes, activities notes, or medical and allied health professionals' notations. Residents and families reported

		participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of generalised care provided to residents was consistent with their needs. Interventions sighted around wound care, nutrition, hygiene, cultural, spiritual and mobility needs was well documented. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a good standard. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by a diversional therapist and an activities co-ordinator. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly, as part of a six-monthly planned activities review, by the diversional therapist. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include outings twice a week, movies, a visiting dog handler, church services visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Residents and family members interviewed confirmed they find the programme meets their needs.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations are not sighted to be occurring every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change (refer criterion 1.3.5.2). Evaluations of wound care are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain, and weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the

		assessment process.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, 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 older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family 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.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed chemical training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	A current building warrant of fitness (expiry date 17 May 2019) is publicly displayed. The current approved fire evacuation plan was not available on the days of audit. The integrity of surfaces in the laundry and a toilet/shower room is compromised and needs addressing. 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 bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment is hazard free, residents are safe and independence is promoted. External areas are safely maintained and are appropriate to the resident groups and setting. Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with

		the environment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single/shared accommodation. Where rooms are shared, approval has been sought. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	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.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site by care staff in a dedicated timeframe allowed for this. 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. There is a small designated cleaning team who have received appropriate training. Staff are appropriately trained in cleaning processes and chemical handling. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are reportedly monitored through the external company's

		audit programme, last in June 2017.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	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 describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service; however, the date is unknown (refer criterion 1.4.2.1). A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 29 November 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the full number of residents. Water storage tanks are located around the complex, and there is a generator available if required. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto outside garden or small patio areas. Heating is provided by electric panel heaters in residents' rooms and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management 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	PA High	The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed by an external advisory body. The infection control programme has not been reviewed annually as required. The GM is the designated infection control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are

scope of the service.		reviewed monthly. Over the past three months, there has been several ongoing 'flu like' and gastro intestinal illnesses at Wensley House. Documentation, interviews and observation have not assessed this as an outbreak, and subsequently no outbreak management strategies have been implemented. A resident with Hepatitis C, has no reference to managing this in the care plan. Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	PA Moderate	The infection control co-ordinator (ICC) has minimal skills, knowledge and qualifications in IC, and has no formal training in the role. Interviews and documentation verify the ICC is unaware of factors the determine an outbreak or that processes aren't documented to guide staff in the management of Hepatitis C (refer criterion 3.1.9). The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.
Standard 3.3: Policies and procedures 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.	FA	The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. With the exception of outbreak management and the management of a resident with hepatitis C, staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions, last held June 2017. Education was provided by suitably qualified RN and the ICC at the time. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was

		maintained. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The ICC reviews all reported infections, however this is often not reported to staff or analysed (refer criterion 1.2.3)
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. On the day of audit, no residents were using restraints and no residents were using enablers. There have not been any restraints or enablers used at the facility in recent years.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.	PA Moderate	The organisation has a recently developed and electronic quality and risk system but not all systems are in place. Documentation to support management of adverse events and quality reporting is available electronically, but has not been imbedded as staff did not have access to the paper format until the days of audit.	There is a documented quality and risk management system, however as this is only a recent system and paper copies only available on the days of the audit staff are not fully aware of the system.	The quality and risk management system is fully implemented and understood by staff. 90 days
Criterion 1.2.3.5	PA High	There are policies and procedures in electronic	There is a lack	Ensure all

Key components of service delivery shall be explicitly linked to the quality management system.		format and included as paper copies for staff on the days of audit. These policies and procedures provide guidance for all staff in service delivery, quality activities and feedback on results at quality and staff meetings. Health and safety and environment issues are consistently being reported and discussed at quality meetings, but not service delivery activities. There is also a lack of clinical incident reporting, including falls, medication errors and infections: Staff during interview state they have reported incidents, however these were not available on the days of the audit. Other incidents, including a reported medication error, and a resident who had a fall was not included documented on incident report forms reviewed. The manager reported she was not always informed of these incidents, and staff confirmed they do not always complete forms. Of incidents documented and reviewed not all are collated, analysed and evaluated to identify trends and manage risks.	of service delivery reporting as agenda items at quality and staff meetings, and clinical incidents are not explicitly linked to the quality management system.	quality activities, including all clinical incidents are included in quality and staff meetings and the quality management system. 30 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA High	Policies and procedures are in place to guide staff in quality improvement systems, however staff have not had access to these policies and procedures. Some accidents and incidents are documented and an immediate action is included on the form, for example 'reminded resident to ring call bell' – however follow-up corrective actions have not been included to ensure the risk is not repeated. Not all clinical incidents are collected, for example a resident who had a fall, and reported medication errors. An incident report was not completed for	Not all quality improvement data is collected, analysed, evaluated and communicated to staff.	Ensure all quality improvement data is collected, analysed, evaluated and communicated to staff. 30 days

		these incidents. There is not an implemented system to analyse data, identify trends, evaluate outcomes and communicate to staff as part of routine quality and staff meetings.		
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Moderate	There are procedures for audit activities included in the recently implemented policies and procedures. However, audits have only been completed on hazards identified in the environment, for example toilets and bathrooms, residents' rooms, electrical safety, carpets and decks. There is not an annual audit calendar in place to routinely complete audits in all areas of service delivery. There has not been a recent resident survey to measure resident and family satisfaction of the service.	Routine audits of service delivery and a resident satisfaction survey have not been implemented.	Implement processes to measure achievement against the quality and risk management system. 60 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Moderate	There is an organisation wide documented risk management plan. All potential risks are identified, documented and a risk severity included with identified frequency of review included. However, the facility has not fully implemented the system (refer also criteria 1.2.3.5; 1.2.3.6; 1.2.3.7; 1.2.4.3)	The facility has not implemented the organisation's documented risk management system.	Ensure all risks identified in the risk management plan are monitored, analysed, evaluated and reviewed at the frequency determined by the severity of the risk.

				60 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	There are documented policies and procedures to address improvements regarding adverse events within the quality and risk management system. A section as a corrective action plan is included on incident and accident forms, and some of these have a sentence to advise the action taken, for example 'remind resident to ring call bell', however a full plan and actions to reduce risks is not included. Of six incident reports reviewed none had the corrective action completed, reviewed or closed out. Not all reported incidents have been documented or analysed to improve service delivery. For example: a resident who had a fall and a medication error.	Documentation regarding adverse events is not always documented or completed to identify service delivery shortfalls or opportunities for improvement.	All adverse events are documented to identify and manage risks. 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA High	Induction and orientation processes for new staff (in three recent files reviewed) have been completed. As required new staff are enrolled in the training as required by the DHB contract. A core skills training session covered fire and emergency training, grief and loss, self-care was held in November. However, mandatory training requirements, such as managing challenging behaviours have not been included. Code of rights and abuse and neglect training has been held in 2017. IPC training was held in June 2017. An annual training plan has not been developed. Competency assessments for key tasks including medications, 'PEG' feeding, basic care procedures have not been completed in the files reviewed. The RNs have not completed medication competencies, PEG feeding or male catheterisation	Staff have not had the required training to safely meet the needs of residents in specific tasks.	Ensure all staff have the appropriate training and competency in key tasks to safely meet the needs of residents. 30 days

		as required in the service agreement D17.7a. There has been no training in Hepatitis C to guide staff in the management of this for a resident. The infection control co-ordinator has not completed relevant training.		
Criterion 1.3.12.1 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.	PA High	The recording of temperatures of the medication fridge occurs daily, however the documented record of the temperatures is higher than the required 8 degrees Celsius over the past month, with no action taken to rectify this finding. Sixteen medication charts evidence good prescribing practices, with the prescriber's signature and date recorded on the commencement and discontinuation of medicines. Ten of sixteen medication charts reviewed were faxed copies and not the original or the most up to date faxed copy. Two staff check the controlled drugs when administering it to a resident; however, both staff do not go to the bedside to ensure the right resident receives the medication. There is no process in place to ensure the controlled drugs are checked by two staff weekly. Systems to manage the review of expired medications are in place; however, when eye drops are opened there is no system in place to ensure they are discarded within their use by dates. Medications are delivered by the pharmacy and locked away. There is no evidence to verify reconciliation of the medications against the medication chart, prior to them being accessible to care staff for administration to residents. A resident recently admitted on warfarin, has no hard	The medication fridge is not operating at the required temperature to ensure safe storage of medicines. The original medication chart is not used being used when administering medications. There is no documented evidence of a weekly controlled drug check. There is no process ensuring the controlled drug is given to the right resident. The management of	Provide evidence medication management processes meets safe medication management guidelines. 30 days

		copy medication chart. The medication has been charted electronically in preparation for the move to electronic medication charts. The care staff are unable to access the electronic record, so are administering the resident's warfarin on the instruction of the RN, who has verified the accuracy of the pack against the electronic order.	eye drops does not ensure the eye drops are disposed of when past their use by date. There is no documentation to verify reconciliation of medications. Medicine management is not in line with safe administration guidelines.	
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	There are policies in place to enable a resident who wishes to self-administer inhalers to do so in a competent and safe manner. Interviews with the clinical nurse leader and the RN were unable to verify knowledge of the policy and safe medicine management guidelines. There is no documentation evident to deem the resident competent of self-administration of medication, nor to ensure this is managed in a safe manner. Interview with the resident verifies the resident is familiar with the responsibilities associated with self-administration.	A resident who self-administers medication has not been deemed competent.	Provide evidence a system is in place to facilitate residents' safe self-administration of medicines. 180 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation,	PA Low	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. A cleaning schedule is in place; however,	A cleaning schedule in the kitchen has no evidence to	Provide evidence of compliance with the cleaning

and guidelines.		there is no evidence of compliance with the schedule since October 2017. The kitchen and appliances are noted to be clean and tidy. A summer and winter menu are operating at the facility. There is no documentation to verify this has been reviewed by a dietician within the past two years.	verify compliance with the schedule. The menu has not been reviewed by a dietician within the past two years.	schedule. Provide evidence that the menu has been reviewed by a dietician. 180 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA High	A resident admitted to the facility had no initial care plan available to staff which identified the resident as a potential wanderer. This resulted in no guidance for staff in regard to the resident's management in the first three weeks prior to a long-term care plan being developed. The resident subsequently wandered away, fell and sustained an injury. Four of four care plans, requiring a review at six months, have not been reviewed. An initiative to implement, update and review an interRAI care plan electronically has been commenced. All care plans and progress notes are to be electronic, with care staff accessing these documents electronically, however this is not yet accessible to care staff. Updated care plans are not accessible to care staff. Care plans are not updated in line with assessment findings, for example, management strategies for caring for a resident with Hepatitis C, management of potential risks of a resident on warfarin, management of the potential risk of a pressure injury (and subsequent development of), individualised management strategies for residents with histories of shortness of breath, reference to a wound and directions on a wound-care plan.	Not all admissions have an initial care plan to guide staff in the residents' management in the first three weeks prior to a long-term care plan being developed. Care plans are not consistently reviewed every six months or as residents' needs change. Care plans, progress notes and updates on care are electronic and are not accessible to	Provide evidence service delivery plans are accessible to all staff, describe fully the required support the resident requires and evaluate the effectiveness of the support to ensure the desired outcome is achieved. 30 days

		A resident who fell and sustained a head injury, has no post fall assessment. An accident and incident form has no corrective actions implemented to address the event and to reduce risks around further falls. There is no evidence a post fall assessment was undertaken (refer criterion 1.2.3.5 and 1.2.3.8). Progress notes for all residents are recorded on one page by care staff and then transcribed electronically into the interRAI care plan by the RN. The intention is for care staff to input and read progress notes electronically. At the time of audit however, care staff have no access to the electronic progress notes. The service was advised to stop this practice and revert to the previous process of care staff handwriting progress notes.	care staff. Care plans are not updated in line with assessment findings and documentation of the required management strategies Progress notes are written by care staff on a one page document that records all the residents. The comments are transcribed electronically in the interRAI care plan by the RN, however care staff have no access to this information. No evidence was sighted of evaluation of the residents' care plans.	
Criterion 1.4.2.1 All buildings, plant, and equipment comply	PA Low	Two showers have had an upgrade in wall surfaces to ensure the area is easily cleaned. Another shower/toilet and the laundry still have not been	Surfaces in the laundry and one shower/toilet	Laundry surfaces and shower walls are

with legislation.		refurbished and have surfaces that are difficult to clean. The manager reports that approval has been provided to have all surfaces remedied. The service did not have available the current NZ Fire Service approved evacuation plan.	walls are compromised making it difficult for effective cleaning. There is no available NZ Fire Service approved evacuation plan.	repaired to ensure surface integrity and effective cleaning, and an approved NZ fire service evacuation plan is required. 60 days
Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.	PA Low	The organisation has a clearly defined infection control programme; however, documentation and interview with staff evidence this has not been reviewed yearly.	The infection control programme has not been reviewed yearly.	Provide evidence the infection control programme is reviewed yearly. 180 days
Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.	PA High	Over the past three months, there has been several ongoing 'flu like' and gastro intestinal illnesses at Wensley House. The advice of a community laboratory, based on the information provided, has been sought, and general infection control practices been enhanced. Over the past three weeks however, ten residents and four staff have experienced gastro-intestinal disturbances, some have resolved, and some remain ongoing. Residents are being placed in isolation. Documentation, interviews and observation have not assessed this as an outbreak, and subsequently no outbreak management strategies have been implemented. Public health has not been notified. Staff verify no increased infection control/outbreak	Outbreak management strategies have not been implemented following several residents and staff experiencing a gastro-intestinal illness. A resident with Hepatitis C has no plan in place identifying strategies to	Provide evidence public health is notified of the current gastro-intestinal illness and evidence of ongoing competency in the management of outbreaks. Provide evidence strategies are in place to manage the resident with

		management training has been provided. The resident with Hepatatis C, has no documented evidence of a plan in place regarding the risk management strategies required to manage a resident with Hepatitis C	manage the risk.	Hepatitis C 30 days
Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.	PA Moderate	The ICC has access to experts with skills in infection prevention and control, however has no formal training and interviews verify is unaware that there is a gastrointestinal outbreak occurring and the significance of outbreak management. There is no strategies in place to guide staff to manage the resident with Hepatitis C	The infection control coordinator has no formal training in infection prevention and control.	Provide evidence the infection control co-ordinator is skilled in infection control. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.