

FOMHT Health Services Limited - Jack Inglis Friendship Hospital

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 Central Region's Technical Advisory Services 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: FOMHT Health Services Limited

Premises audited: Jack Inglis Friendship Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 8 May 2018 End date: 10 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: 65

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

Jack Inglis Friendship Hospital can provide care for up to 77 residents, with rest home, hospital and dementia level services. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with the chair and director of the trust board, a director of residents, residents, family, management, staff and general practitioners.

Jack Inglis Friendship Hospital is governed by a trust board with a general manager reporting on operational matters. The general manager is responsible for the overall management of the facility and supported by the management team, including the clinical manager, the clinical nurse leader and the quality assurance manager. The clinical manager and clinical nurse leader have both resigned and the service has appointed an in-house registered nurse as the new clinical manager.

Corrective actions are required around the management of residents personal belongings, residents not being subjected to risk of abuse, evidence based practice, open disclosure and communication, management of the complaints process and complaints register, corrective action plan management, adverse event reporting, staffing levels, timeframes for service delivery, assessments not consistently completed, care planning, interventions not always reflecting residents' needs, planned activities for residents in the dementia unit not being aligned with their specific needs, evaluation not reflecting achievement of goals, incomplete short-term plans, safe medicine management processes, the infection control programme and infection control policies. There are five high risk findings.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--	--	--

Staff members were able to demonstrate an understanding of their responsibilities and resident rights. Residents have access to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights information, and the facility displays complaint forms at reception. Nationwide Health and Disability Advocacy Service brochures can be accessed at reception.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Linkages with family and the community are encouraged and maintained. There is a system in place to ensure Māori values and beliefs are recognised should the service admit residents who identify as Māori.

There were two Health and Disability Commission complaints of which one was closed out at the time of audit and one complaint to the district health board.

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.
---	--	--

Jack Inglis Friendship Hospital has a mission statement with their vision displayed in the facility and strategic plans documented. The strategic and business plan include business strategies for the organisation. The Jack Inglis Friendship Hospital trust board is the governing body and meets regularly with the general manager who is responsible for operational management of the facility. The general manager is qualified for the role.

The quality and risk system and processes provide guidelines for service delivery. The quality management system includes facilitation of an internal audit process, complaints management, surveys, incident/accident, training, restraint management and infection control management. Reporting processes include external benchmarking.

There are human resource policies in place to guide practice.

Resident information is identifiable, recorded, current, confidential, accessible when required and securely stored.

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 with the Needs Assessment Coordination Service to ensure access to the service is efficient with all relevant information available.

Residents receive services from suitably qualified and experienced staff. The registered nurses are responsible for completing the initial assessments, including interRAI, the initial care plans, the short-term care plans for acute conditions and the long-term care plans for long-term service delivery.

Residents are referred or transferred to other health services as required with appropriate verbal and written handovers.

The planned activities programmes are overseen by a diversional therapist. The programmes provide residents with a variety of individual and group activities and maintain their links with the community.

Staff responsible for medicine management attend medication management in-service education and have current medication competencies.

Staff deliver food services via a central kitchen on site. Additional modified dietary and nutritional requirements are being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
--	--	--

The buildings and plant comply with legislation with a current building warrant of fitness in place.

A preventative and reactive maintenance programme includes equipment and electrical checks. The service includes systems to ensure the environment for residents, staff and visitors is clean and safe. There is a cleaning schedule and cleaning staff are trained. There is a system for segregation and disposal of waste which is aligned with policy. Hazardous substances and chemicals are stored appropriately.

Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Residents' rooms are of an appropriate size for staff and residents to move around freely, to allow for care to be provided and for safe use and manoeuvre mobility aids.

There is a secure unit for residents requiring dementia level care with a secure courtyard that includes a path, gardens and outdoor areas for leisure.

Laundry services are completed on-site.

Essential emergency and security systems are in place with regular fire drills completed. Call bells are in place. Jack Inglis Friendship Hospital has developed and maintained plans to respond to emergency situations, including medical emergencies. There is equipment and supplies available on site in the event of an emergency.

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 restraint minimisation policy and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

There were no residents using restraints and one resident requesting the use of an enabler on audit days.

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 low risk.
---	--	---

The clinical manager is the infection control coordinator. They are responsible for staff education in infection control and the surveillance of infections at the facility.

New employees are provided with training in infection control practices and there is ongoing infection control education available for staff. Staff are familiar with infection control measures at the facility.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	29	0	5	7	4	0
Criteria	0	74	0	6	8	5	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	The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is displayed at the entrance of the facility and pamphlets are available at reception. Residents and families are provided with copies of the Code as part of the admission process. Staff interviewed demonstrated knowledge and understanding of the requirements of the Code.
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	There is an informed consent policy and procedure which guides staff in relation to their practice when gathering informed consent. Staff interviews confirmed that residents and family have consent processes completed where treatment and interventions require informed consent. All resident files reviewed showed that informed consent was obtained. Interviews with staff confirmed their understanding of informed consent processes. The registered nurse or the clinical manager discusses informed consent processes with residents and their families/whānau during the admission process. The policy and procedure include guidelines for consent for resuscitation/advance directives. Service information packs include information regarding informed consent. Where resident files recorded advanced

		directives, the resident was confirmed competent to make the decision.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>The Health and Disability Commissioner's information on advocacy services is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Information brochures on advocacy services is available at the entrance to the facility.</p> <p>Staff training includes training on the Code with this provided annually. Discussion with family and residents identified that they have been informed about advocacy services. The resident files included information on resident's family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy and residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families confirmed they could visit at any time, however, residents are not always presentable (refer to 1.3.7.1).</p> <p>Residents are encouraged to be involved in community activities and to maintain networks with family and friends. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA High	<p>Policy and procedures identify the organisations' pathway for the management of complaints. The organisation's complaints policy and procedures include timeframes for responding to a complaint. Complaints management is explained as part of the admission process for residents and family/whānau and is part of the staff orientation programme and ongoing education. Complaint forms are available at reception and the facility has a 'mail box' for submitting complaints anonymously.</p> <p>Staff confirmed that they understand and implement the complaints process for written and verbal complaints when they occur. These complaints are reported to the clinical manager (CM) who records and collects information around each complaint. The CM confirmed this process and explained that the complaints are then individually discussed with the general manager (GM) and the written complaints report is then given to the GM who manages all complaints.</p> <p>A complaints register is in place. Review of the 2017 (May to December) and 2018 complaint documentation did not always show in-depth investigation of complaints and associated</p>

		<p>corrective action plans or quality improvement activities as a result of the investigation, when required. Written evidence of resolution of the complaints was demonstrated by letters explaining the processes/expectations of the facility, rather than information on what the outcome of the investigation was. Complaint forms are not consistently fully completed (refer to 1.2.4.3).</p> <p>Complaints that were discussed by residents, family and staff, during the on-site audit did not all feature in the complaints register. Verbal complaints are not consistently recorded in the complaints register. Complaints in relation to certain staff could not be verified in the complaints register (refer 1.1.3.7).</p> <p>Although some of the complaints were closed, staff, residents and family confirmed through interviews that they are dissatisfied with the complaints process, particularly with regard to the outcomes of complaints. Residents and family stated they are not always kept informed of the progress or outcome of the complaint.</p> <p>Since the last audit there have been two complaints lodged with Health and Disability Commissioner of which one is closed and one complaint to the DHB.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information about the Code is provided in all new residents' information packs. Staff interviews confirmed discussions relating to the Code are held at the resident meetings.</p> <p>If necessary, staff can read and explain information to residents as stated by the caregivers and registered nurses interviewed. The Code is also available in te reo Māori and other languages. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private if this is required. Posters on the Code identify residents' rights and advocacy services. These posters are in te reo Māori and English.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	PA High	<p>The facility has systems in place to ensure staff respect the physical, visual, auditory, and personal privacy of the residents and their belongings, however, this system was not satisfactory for all residents. A policy is available to guide staff to assist them with managing resident independence, privacy, dignity and respect. Residents' personal belongings are used to decorate their rooms and create their own space. Discussions of a private nature can be held in the resident's room and there are areas in the facility which can be used for private meetings.</p> <p>Caregivers reported that they encourage the residents' independence and for residents to be as active as possible. The service contracts a physiotherapist who helps with independence</p>

		<p>and mobility of residents. Caregivers interviewed reported that importance of knocking on bedroom doors prior to entering rooms, ensuring doors are shut when cares are provided and not discussing residents or their care in public places, however, this practice does not always occur. Family and residents interviewed reported that staff do not always respect the residents' privacy or dignity (refer to 1.3.7.1). Care staff, families and residents stated that staff are at times verbally abusive and physically rough with residents (refer to 1.1.13.1).</p> <p>Residents' bedrooms are single or shared for those couples who choose to stay together and share. There are curtains in rooms that allow residents who share rooms to have personal privacy.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>The Māori Hononga/Relationship Plan 2016-2018 guides staff to ensure cultural safety and eliminate cultural barriers, should Māori residents enter their service. The rights of the residents/family to practise their own beliefs are acknowledged in this Māori health plan.</p> <p>Links to local iwi are documented. There are staff who identify as Māori. Staff interviews confirmed that specific cultural needs are identified in the residents' care plans and this was sighted in files reviewed. Staff are aware of the importance of whānau in the delivery of care for the Māori residents. A cultural assessment is completed as part of the care plan for all residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has policies and procedures to ensure the recognition of Māori values and beliefs and that of other cultures. Residents/family verified they were consulted on their ethnicity, culture, values and beliefs. Staff are educated as part of the mandatory education provided on cultural safety and cultural appropriateness. The Code of Rights is available in te reo Māori and different formats. Chaplaincy services are offered to residents and their families as needed or requested.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff files reviewed evidenced job descriptions and employment agreements that include guidelines regarding professional boundaries. Families, residents and staff expressed concerns with breaches in professional boundaries, discrimination or harassment (refer to 1.1.3.7, 1.1.13.1 and 1.3.7.1).</p> <p>The orientation and employee agreement provided to staff on induction includes standards of conduct. Allied health and medical professionals abide by the regulatory bodies to which they</p>

		belong. There were complaints recorded relating to allegations of abuse (refer to 1.1.3.7, 1.3.7.1 and 1.1.13.1).
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	PA Low	<p>The facility has policies and procedures in place to guide practice. These policies are reviewed two yearly or as changes occur, however, not all policies reflect or refer to applicable legislation. The service has a process for introducing new policies into their service ensuring staff read and acknowledge new policies. Their quality and risk management framework supports an internal audit programme. Benchmarking occurs using national data.</p> <p>There is an annual training programme implemented. Staff confirmed care plans and information in relation to resident's care is given to them at handover by the registered nurse. Specialised training and related competencies are in place for the clinical staff.</p> <p>There are weekly management and monthly quality and clinical meetings attended by managers and staff. Five general practitioners (GP), from both practices located in Motueka, reported concerns relating to the facility's high turnover of staff (refer to 1.2.8.1).</p> <p>Work has been completed to improve the culture of the service, to improve management of falls and to the quality and risk management programme.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Moderate	<p>Family contact is recorded in residents' files. The service has processes in place for guiding staff to ensure full and frank open disclosure was available, however, these processes are not always used effectively. Staff, resident and family interviews confirmed that they are not always informed of survey results, complaint outcomes and service information. The audit team reviewed admission agreements which were not consistently signed or signed within the expected 10 days after admission to the facility. Very few clinical incident/accident records were available for review during the on-site audit.</p> <p>Whilst the complaints procedure, the open disclosure procedure and the documentation reviewed during the audit demonstrated close out of complaints and issues, there was no evidence documented of complainant satisfaction or resolution of the complaint for residents and or their families (refer to 1.1.13.1). Family interviews also confirmed that they are not always invited to the care planning meetings for their family members and there was no evidence of family meetings being held for residents who reside in the dementia unit (refer to 1.3.7.1). Families of residents in the dementia unit are unable to access or exit the dementia unit as they are not provided with access information and require a staff member to assist when entering/exiting the dementia unit (refer to 1.3.7.1).</p>

		<p>Interpreter services are available from the district health board. Staff demonstrated an understanding of how to access interpreter services when required. There are no residents requiring interpreting services. The information pack is available in large print and this could be read to residents.</p> <p>The recent satisfaction survey report indicated that there are areas where residents and family are not satisfied with communication or care and support provided.</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>Jack Inglis Friendship Hospital has a documented vision, mission statement, philosophy and values. These are displayed in the facility and communicated to staff at orientation and through training.</p> <p>The service provides dementia, rest home and hospital level of care under the aged care contract. The service is able to provide support for a maximum of 77 residents with 62 dual purpose beds, which can be used for either hospital or rest home care and an additional 15 beds for providing dementia level of care.</p> <p>Occupancy on the first day of audit was 65, including 21 residents receiving hospital level care, 27 residents receiving rest home level of care and 14 residents in the secure unit and 3 residents receiving respite care. Within these numbers, there were two residents under the young persons with disability contract, with one resident receiving rest home care and one receiving hospital care, two residents receiving rest home care under the Accident Compensation Corporation contract and two residents under a primary care contract.</p> <p>The trust board is responsible for governing the facility and the board meets monthly. The board has eight members from the community that includes expertise in finance, business management and one medical professional. Interview with a director and the chair to the trust board confirmed they are currently in the process of looking to include another board member with clinical expertise.</p> <p>The GM has experience in aged care with previous experience in accounting, management roles and nursing. The GM is a registered nurse, has been in the role for four years and is supported by other members of the management team. The management team includes the GM, clinical manager (CM), clinical nurse leader and quality assurance manager. Communication between the managers takes place at weekly intervals. The personnel files of the management team indicated that they have attended education relevant to their roles with each having a performance appraisal completed annually.</p> <p>The CM is in the process of receiving orientation to their role. The previous CM resigned and was still in the process of completing orientation and induction with the new CM when, during</p>

		<p>the onsite audit, was asked to leave and not return.</p> <p>The CM role was not formally advertised. Registered nurses employed in the facility were informed via memo and displayed in the staff room of the clinical manager position. One RN showed interest and was appointed as the new CM. The auditors could not verify that HealthCERT was informed about this appointment as the CM (refer to 1.2.8.1).</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>In the absence of the GM, the quality assurance manager and the CM share the role of standing in for the GM. The newly appointed CM is a registered nurse who has been with the service for several years and can be supported by the clinical consultant.</p> <p>The quality assurance manager is a registered nurse with previous experience in community nursing. They have a postgraduate diploma in tamariki ora and in palliative and hospice care.</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>	PA Low	<p>The quality and risk management framework and organisational policies and procedures are in place to guide service delivery. Policies are subject to reviews at regular intervals. The management team review policies.</p> <p>Policies are linked to the Health and Disability Sector Standards and are current, however, not all policies reflect relevant legislation (refer to 1.1.8.1). Policies are available to staff in hardcopy and revised policies are made available to staff to read and sign that they have read and understood the new/revised policy.</p> <p>Service delivery is monitored through review of incidents and accidents (reviewed collation of incident and accidents data), however, incidents and accident records for some of the clinical issues that occurred could not be verified, this includes incidents and accidents relating to medicines management errors (refer to 1.2.8.1 and 1.3.12.1). The quality system also includes complaints management (refer to 1.1.13.1 and 1.1.13.3); surveillance of infections (refer to 3.1.3 and 3.3.1); pressure injuries; wounds; implementation of an internal audit programme and meetings.</p> <p>Corrective actions as identified in meeting minutes do not consistently record timeframes for implementation or sign-off after implementation of changes, this also applies to incident/accident reporting and implementation of corrective actions as part of the complaints process (refer 1.1.13.1).</p> <p>The service holds monthly staff meetings, including quality improvement, health and safety and infection control. There is evidence of three monthly resident meetings coordinated by the</p>

		<p>diversional therapist which inform residents of changes in the facility. Family are allowed to attend the meetings, however, interviews confirmed they do not always know when resident meetings are taking place (refer to 1.1.9.1).</p> <p>Health and safety policies and procedures are documented along with the hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified, with the maintenance person addressing hazards to minimise risks. The maintenance person resigned two weeks ago, one of four key people that left the service over the six weeks prior to audit (refer to 1.2.8.1).</p> <p>Survey for family and residents was completed in 2018 and issues were raised including laundry (1.1.3.1), communication and feedback (1.1.9.1), complaints management (refer to 1.1.13.1) and staffing concerns (1.2.8.1).</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>	PA Low	<p>The GM is aware of situations in which the service is required to report and notify statutory authorities. Interviews with staff members and record reviews confirmed that staff understand their responsibilities around incident and accident documentation. Adverse, unplanned or untoward events are recorded on incident/accident forms (refer to 1.2.3.8), however, these forms are not consistently fully completed.</p> <p>There have been no adverse events resulting in the GM having to inform the coroner, the DHB or HealthCERT.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>All staff files reviewed showed evidence that staff complete an orientation programme. Newly appointed caregivers are paired with a senior caregiver as part of the orientation and induction programme (refer to 1.2.8.1).</p> <p>All staff files included evidence of referee checks; signed employment contracts; job descriptions; police checks (refer to 1.1.3.1; and 1.2.8.1); orientation and induction records (refer to 1.2.8.1); copies of qualifications; practising certificates where applicable; evidence of having completed training; current performance appraisals; confidentiality agreements and where applicable interRAI training.</p> <p>Registered nurses hold current annual practising certificates along with other health practitioners in the service. Eight registered nurses have completed and have current interRAI competencies.</p> <p>Annual competencies are completed by clinical staff. The facility has a mandatory education</p>

		<p>and training programme with an annual training schedule documented. Staff attendances of training sessions was documented.</p> <p>Education and training hours are at least eight hours a year for each staff member.</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>	PA High	<p>The staffing rationale is stated in policy to guide workforce planning. Guidelines include processes to guide staffing levels and skill mix. Staff file reviews included processes in relation to human resource management, including requirements relating to skills and knowledge for each position, job descriptions, accountability, responsibilities and authority. The management team and a senior registered nurses are on call.</p> <p>The GM has delegated authority to make operational and financial decisions relating to staff management, turn over, recruitment and replacement of staff. The GM reports monthly to the Board and reports reviewed indicated that staffing levels are satisfactory with no concerns for safety. This was confirmed during interview with members of the board. Monthly reports from the CM, included in board reports reviewed over the last six months, raised concerns around staffing numbers. Staffing levels have declined from 130 in 2014 (as per board report June 2017) to 76 currently, with a staff turnover rate calculated by the audit team of approximately 50% for the 2017 year.</p> <p>Staff interviews confirmed that new staff often leave before completing orientation and induction. These processes do not consistently ensure safe, appropriate or good practice. Employment processes especially around the appointment of the CM could not be verified as best practice. There was also no evidence of a letter confirming this appointment or notification to HealthCERT that there was a change in clinical managers.</p> <p>Rosters are prepared six weeks in advance by the GM. Rosters do not always reflect real time staffing, with approximately 18 gaps per week to be filled, as evidenced in the sampling of rosters undertaken. A casual pool of approximately five staff is available to fill gaps in the roster, with current staff covering the remaining gaps.</p> <p>Police and criminal vetting occurs, however, not all staff evidenced recent police vetting, including those with prior convictions and subsequent risk to residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely</p>	FA	<p>There are policies and procedures in place to ensure privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records.</p> <p>The service maintains relevant and appropriate information to identify residents and track</p>

identifiable, accurately recorded, current, confidential, and accessible when required.		<p>records. This includes using comprehensive data from the admission process and information as provided by family. There is sufficient detail in resident files to identify residents' ongoing care history and activities. Information containing sensitive resident information is not displayed in a way that it could be viewed by other residents, their families or members of the public.</p> <p>Entries to resident files are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including designation. Approved abbreviations are listed. The resident's national health index number, name, date of birth and GP are used as unique identifiers.</p> <p>Resident files are protected from unauthorised access by being locked away in an office. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</p> <p>Individual resident files demonstrate service integration. This includes medical care interventions. An electronic medication management system is in place.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The residents are admitted to the facility when their level of care has been assessed and confirmed by the Needs Assessment and Service Coordination (NASC) service. Prospective residents and/or their families are encouraged to visit the facility prior to admission, confirmed at interviews. Facility specific information about the service is provided for residents and their family.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer from the facility is managed in a planned and coordinated manner. Communication between the services, the resident and the family occurs. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes. Transfer back to the facility is managed by the DHB with phone calls and provision of medical discharge summaries and transfer information (refer to 1.3.3.3).</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe</p>	PA High	<p>Medication areas, evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Drug registers are maintained and evidenced weekly checks and six monthly physical stocktakes. The medication fridge temperatures are conducted and recorded.</p>

practice guidelines.		<p>The facility uses a combination of computerised medication charts for permanent residents and hardcopy/hand written medication charts for respite residents. Review of the computerised medication charts evidenced they complied with current legislation requirements and safe practice guidelines. The administration of medicines from hardcopy medication records did not comply with legislation (refer to 1.2.8.1 and 1.2.3.8).</p> <p>All staff authorised to administer medicines have current competencies. The medication rounds were observed and evidenced the staff members were knowledgeable about the medicine administered and signed off, as the dose was administered when the computerised system was used. Administration records are maintained, as are specimen signatures. Staff education in medicine management is provided.</p> <p>There was one resident assessed by the GP as competent to self-administer medicines at the facility.</p> <p>Registered nurses stated medication errors are reported and recorded on an incident form (refer to 1.2.4.2).</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu. The menu was reviewed by a registered dietitian in March 2018 and there are recommendations that require actions. A corrective action plan was sighted for the actions required (refer to 1.2.3.8).</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Review of the dietary profiles in the kitchen evidenced there were residents' dietary profiles dating back to 2012. There were 5 resident's profiles dated 2015 and 11 profiles dated 2016 (refer to 1.3.3.3).</p> <p>The personal food preferences of the residents, special diets and modified nutritional requirements are known to the kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs was sighted. Observation of the meal service in all areas evidenced the resident's food preferences were known to staff and adhered to.</p> <p>The aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. The effectiveness of chemical use, cleaning, and food safety practices in the kitchen are monitored.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>If a referral is received, and the prospective resident does not meet the entry criteria or there is no vacancy at the time, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. Interview with management verified a process exists for informing residents, their family and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely manner.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Moderate	<p>On admission, residents have their needs identified through a variety of information sources that include: the NASC; other service providers involved with the resident; the resident; family and on-site assessments using a range of assessment tools (refer to 1.3.3.3).</p> <p>The assessment process takes place in the privacy of the resident's bedroom with the resident and/or family present if requested.</p> <p>The required assessments are not consistently completed as required.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>The assessment findings in consultation with the resident and/or family, inform the care plans (refer to 1.3.3.3 and 1.3.4.2).</p> <p>The residents' care plans are integrated and up to date. The short-term care plans are developed, when required and signed off by the RN when problems are resolved, however, the required interventions are not always recorded (refer to 1.3.8.3).</p> <p>There is evidence of service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written.</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>	PA Moderate	<p>Any changes in resident's condition are reported in a timely manner to the GP and prescribed orders are followed as confirmed in the GP interview. The progress notes are completed on every shift. Monthly observations such as weight and blood pressure are completed and are up to date. Observations are conducted more frequently if required.</p> <p>There was evidence of clinical equipment and supplies required to provide care services in the rest home, hospital and dementia care, however, the clinical equipment that was required by a hospital resident was not provided.</p>

		<p>There is evidence of wound care products available at the facility, however, the products used are not in line with good practice.</p> <p>The staff interviews confirmed they have access to the supplies and products they require to meet the needs of the residents.</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>	<p>PA Moderate</p>	<p>The facility employs one diversional therapist (DT) and three activity coordinators (AC). There are three activities programmes at the facility: one for hospital and rest home residents; another for residents with dementia and another for day care clients. Residents are able to attend the day care activities programme if they wish, confirmed at activities staff interviews. The activities are provided six days a week with Sundays free for family and friends visits. The activities are provided up to 5pm, this includes the activities in the dementia unit. The activities staff reported that they modify activities based on the residents' responses and interests and also according to the capability and cognitive abilities of the residents. Residents' attendances at activities are monitored.</p> <p>The GM stated the activities services at the facility are presently being reviewed, confirmed at activities staff interviews.</p> <p>The residents' social and recreational assessments are not always completed within the stated timeframe to ascertain the residents' needs, interests, abilities and social requirements. The residents' activity care plans are not always completed within the required timeframe following resident's admission to the facility or consistently evaluated six monthly (refer to 1.3.3.3).</p> <p>The residents were observed to be participating in meaningful activities on audit days and to be going offsite with family/friends. There are planned activities and community connections that are suitable for the residents.</p> <p>There is a form titled: "24 hour activities plans" in clinical files of residents' with dementia, however, these plans do not provide specific descriptions of how a resident's behaviour is best managed over a 24 hour period.</p> <p>A residents' meeting is held bi-monthly. Residents meeting minutes evidence the activities programme is discussed and surveys are completed (refer to 1.2.3.8).</p> <p>There are no family meetings provided for family who have residents with dementia residing at the facility. The family/visitors are unable to access or exit the dementia unit as they are not provided with access information and require a staff member to assist when entering and exiting the dementia unit (refer to 1.1.9.1).</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>The timeframes in relation to care planning evaluations are documented. The residents' care plans are up to date, however, not consistently reviewed six monthly (refer to 1.3.3.3).</p> <p>The residents' progress notes are entered on each shift. When resident's progress is different than expected, the RN contacts the GP, as required. The GP interviews confirmed a timely contact is made to inform them when residents' condition change. Short-term care plans are in some of the residents' files, used when required, however, the short-term care plan interventions are not consistently completed. The family are notified of any changes in resident's condition, as confirmed at family interviews and evidenced in the residents' clinical files.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or the CM sends a referral to seek specialist service provider assistance. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The service has documented processes for the management of waste and hazardous substances. Incident and accident reports relating to non-clinical matters are documented and reported in a timely manner. Policies and procedures specify labelling requirements, including the requirements for labels to be clear, accessible to read and free from damage.</p> <p>Material safety data sheets are available throughout the facility. The maintenance person who recently resigned has been replaced by the gardener, who now is responsible for both these roles (refer to 1.2.8.1). Interviews confirmed that this appointment is so new that employment documentation, orientation and job-descriptions have not been finalised.</p> <p>The hazard register is current. Staff receive training and education in safe and appropriate handling of waste and hazardous substances. There is provision and availability of protective clothing and equipment. During a tour of the facility protective clothing and equipment was observed in high risk areas. Chemicals are labelled throughout the facility. There are sharps</p>

		<p>bins utilised. Infection control policies state specific tasks and duties for which protective equipment is to be worn.</p> <p>Chemicals are stored in a designated chemical storage shed, with appropriate signage.</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	<p>A current building warrant of fitness is displayed. There have been no building modifications since the last audit.</p> <p>The service has a planned and reactive maintenance schedule implemented with an annual test and tag programme. Calibrating of clinical equipment occurs annually. Interviews with staff and observation of the facility confirmed there is adequate equipment.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet. There are areas with shade and outdoor furniture and a veranda with walkways enabling residents to mobilise safely outside.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>The service has adequate numbers of accessible toilets/bathing facilities with a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas. Resident, family and staff interviews confirmed having access to equipment and or accessories to promote resident mobility and independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate personal space provided in bedrooms to allow residents and staff to safely move around and manoeuvre equipment such as wheelchairs, within the room. Rooms are individualised with furnishings, photos and other personal possessions. Residents and their families are encouraged to make their suite their own.</p> <p>The facility provides areas designated to store mobility aids, hoists and wheelchairs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe,</p>	FA	<p>The service has lounge and dining areas including areas that can be used for activities. Residents are observed to being able to move freely and dining areas have space to facilitate all dining residents. Residents confirmed there are alternate areas available to them if</p>

adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		communal activities are being run in one of these areas. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents can choose to have their meals in their room.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry policies and procedures are documented and guide services at the facility. There are processes in place for collection, transportation and delivery of linen and residents' personal clothing (refer to 1.1.3.1). All laundry, including residents' personal laundry, is completed on site (refer to 1.1.3.1). There is a dirty area in the laundry to place the laundry bags and a separate clean area for clothes and linen. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility.</p> <p>Cleaning is monitored through the internal audit process with no issues identified in audits. There is a dedicated secure storage area for cleaning equipment and chemicals. The cleaners were observed to have the trolley in the room with them when cleaning and all had appropriately labelled containers on the trolleys. Cleaner interviews describe the management of cleaning processes including the use of personal protective equipment.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The service has a fire evacuation plan which is approved by the New Zealand Fire Service. The evacuation policy guides emergency and security processes. The service completes fire drills at six-monthly intervals. The orientation programme includes fire and security training. Fire equipment was sighted on the day of audit. Fire testing occurred during the on-site audit.</p> <p>Although there have been several complaints around call bells not being answered, being unplugged and or moved out of reach of the resident and false fire alarms having occurred (refer to 1.1.13.1 and 1.2.8.1), the audit team did not evidence equipment, including call bells, not working. Call bells can be accessed in all resident rooms, toilets, communal areas including dining areas. Call bell audits are routinely completed. Sensor mats are used where appropriate.</p> <p>The service has a disaster management plan with guidelines for staff. There are adequate emergency supplies, including food, water, blankets, emergency lighting and a gas barbeque.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	Residents are provided with adequate natural light, safe ventilation, heating and the environment is maintained at a safe and comfortable temperature. There are procedures to

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		<p>guide service delivery around maintaining a safe environment.</p> <p>Families and residents confirmed that rooms are maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	PA Low	<p>The CM is the designated infection control coordinator (ICC), whose role and responsibilities are defined in a job description. The CM, was orientating the incoming new CM to this role. The newly appointed CM stated they were participating in their orientation, however, there was no recorded evidence of an orientation specific to the role of the ICC or a position description for this role for the new CM (refer to 1.2.8.1).</p> <p>The CM stated they have access to external specialist advice from GPs and a microbiologist when required. Infection control matters, including surveillance results, are reported monthly to the quality assurance manager.</p> <p>Signage at the entrances to the facility requests visitors not to enter the facility if they have been unwell.</p> <p>There was no recorded evidence of the infection control programme available on audit days or evidence of annual reviews of the programme specific to this facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The current ICC has appropriate skills, knowledge and qualifications for the role. The ICC has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. The incoming CM who will be the new ICC stated they have experience, knowledge and education in infection control matters.</p> <p>The ICC indicated there are adequate resources for this role to undertake surveillance and investigations respectively.</p> <p>The ICC has access to relevant and current information which is appropriate to the size and complexity of the service, including but not limited to: infection control manual; internet; access to experts; and education. Infection control quick reference flip charts are displayed throughout the facility. The ICC stated they have access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. Interviews with GPs confirmed they are informed of any changes in residents' conditions in a timely manner.</p>
Standard 3.3: Policies and procedures	PA Low	There are minimal facility specific infection control policies available. The service uses a

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.		generic, external infection control policy manual as the facility's infection control policy manual. Care delivery, cleaning, laundry and kitchen staff were observed using disposable aprons, gloves, hats, as was appropriate to the setting. Staff demonstrated knowledge on the requirements of standard precautions.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control education is provided to all staff at orientation and as part of the in-service education programme. The staff in-service education is provided by the ICC, as confirmed at interviews. In interviews, management and staff advised that clinical staff identify situations where infection control education is required for a resident such as: hand hygiene or cough etiquette, one on one education is conducted. External contact resources include: GPs; microbiologist; and infection control specialists/consultants. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.
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	The ICC is responsible for the surveillance of infections at the facility. The type of surveillance undertaken is appropriate to the size and complexity of this service. Infection data is collected by the ICC and reported to the quality assurance manager. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes from the external resource manual (refer to 3.3). Benchmarking is undertaken by an external company and this information is shared with management and staff. The GPs are informed within the required timeframe when residents have infections and appropriate antibiotics are prescribed to combat the infections respectively, confirmed at GP interviews. Residents' files evidenced the residents' who were diagnosed with infections had short-term care plans in place (refer to 1.3.8.3). In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RN's, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files. Interviews with management and staff confirmed there were two outbreaks at the facility, one

		at the end of 2017 and the other at the beginning of 2018. Reports sighted relating to the outbreaks evidenced relevant data was obtained and authorities were notified.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint minimisation and safe practice policy that includes restraint and enabler definitions that are congruent with this standard. The restraint minimisation education is included in the orientation programme and the in-service education plan.</p> <p>On audit days, there were no residents assessed as requiring restraint and one resident requesting the use of an enabler. The review of the clinical file of the resident who requested the enabler use evidenced: the enabler use was a request from the resident; consent was obtained; assessment recorded; and approval, evaluation and monitoring of the enabler use was conducted. Management and staff interviews evidenced their knowledge relating to restraint and enabler use.</p> <p>The restraint coordinator is the CM, who was orientating the incoming new CM to this role. The newly appointed CM stated they were participating in their orientation, however, there was no recorded evidence of an orientation specific to the role of the restraint coordinator or a position description for this role for the new CM (refer to 1.2.8.1).</p> <p>Environmental restraint is in use in the dementia unit. Interviews with management, staff and family members confirmed the family members are not provided with information relating to access and exit from the dementia unit. The family members cannot access or exit the unit independently and require a staff member to enable them to do this (refer to 1.1.9.1).</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 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA High	<p>A complaints process is in place. Staff are aware of the process, however, the complaints management process does not consistently evidence outcomes of complaints leading to quality improvement activities. Resident, family and staff family interviews raised concerns that there is either no feedback/limited feedback on the outcome of investigations or how the facility intend to prevent any repetition of incidents that led to the complaints (refer to 1.1.1.9).</p> <p>Complaints are being closed out, however, some of the complaints are considered unresolved by the complainants (confirmed during interviews). Residents (6 of 6); family (4 of 4); and staff (13 of 15) who made complaints, confirmed in interview they are not satisfied with the complaints process, the way in which the complaints are investigated, the outcomes and feedback after a complaint is closed. This dissatisfaction was verified in the 2018 resident and family satisfaction survey results sampled (8 respondents of 20) surveys reviewed were dissatisfied with aspects of the complaints process, including residents and family cared for in the rest home, hospital and dementia unit.</p> <p>A formal letter from 13 local GPs was responded to by the GM. This remains an</p>	The complaints process does not always evidence a fair, responsive approach as required under Right 10 of the Code.	<p>The complaints process to align with the requirements of the Code.</p> <p>60 days</p>

		<p>unresolved complaint by the complainants. Another complaint by the GPs was sent to the DHB, which remains an open, unresolved complaint as per the GPs interviewed. Other examples were reported to the audit team, with regard to families requesting further information about the complaint or to meet with the GM to further discuss resolution of the facility closed out complaint.</p>		
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA High	<p>Complaints registers are in place and complaints which were recorded from May 2017 to May 2018 were reviewed. The process as per staff interviews, confirmed that verbal complaints are to be recorded and reported to the GM for implementation of the complaints process. The complaints process as documented in the complaints registers include: the date the complaint is received; the source of the complaint; a brief description of the complaint and the date the complaint was acknowledged. The complaints register also includes opportunity to record what was done to investigate the complaint and the name and signature of the GM at sign-off of the complaint.</p> <p>Written complaints, as reflected in the complaints register, ranged from issues around call bells not being answered in a timely manner and being unplugged, staff being physically rough, injuring residents (refer 1.1.3.7), a fire alarm going off at night, with an automated voice imploring residents to evacuate, and residents, who could not evacuate without assistance, not being informed of what was happening resulting in a resident stating they were 'waiting to be burned alive' (refer to 1.1.3.7 and 1.2.8.1); concerns about a resident receiving terminal care not having been cared for appropriately (refer to 1.3.3.3; 1.3.4.2; 1.3.5.2; 1.3.6.1; 1.3.8.2; 1.3.8.3), staffing levels not being safe (refer to 1.2.8.1), residents property disappearing (refer to 1.1.3.1), and several occasions of staff being verbally abusive (refer to 1.1.3.7).</p> <p>Verbal complaints are not consistently recorded in the complaints register. Some of these complaints include verbal and physical abuse (refer to 1.1.3.7). Complaints in relation to a staff members conduct as per staff and resident interviews, could not be verified as having been recorded or managed and are not reflected in the complaints register. Interviews with residents, family and staff confirm that not all complaints are documented and managed according to the requirements of the Code.</p> <p>Verbal and written complaints (according to residents, family and staff interviews) which were not included in the complaints register include; additional incidents of</p>	<p>Not all complaints are documented in the complaints registers.</p>	<p>All complaints to be documented in the complaints register.</p> <p>60 days</p>

		residents being verbally abused, further incidents of residents being hurt during cares, a resident having water poured over their body, a resident being slapped in the face (in addition to a known formalised complaint), verbal abuse of a family member, a volunteer experiencing humiliation and verbal abuse by a senior staff member, a resident smelling of vomit and faeces, residents not being cared for according to their needs and their dignity not maintained (refer to 1.1.3.7 and 1.1.3.7), a nurse introducing themselves as a medical doctor (1.2.8.1), rosters not consistently reflecting real time staff on duty (refer to 1.2.8.1).		
<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	PA Low	<p>Residents are addressed by their preferred name (refer to 1.1.3.7 and 1.1.13.1) and this is documented in files reviewed. The facility has systems in place to ensure staff respect the residents and their belongings, however, this system is not effective for all residents, as per interview and review of resident and family satisfaction results.</p> <p>Resident and family interviews confirmed that clothing and sometimes other personal belongings disappear and are not found. On interview there were also families and residents who stated they have witnessed other residents wearing their family member's clothes (refer to 1.1.13.1). The 2018 survey results identified 8 of 20 responses dissatisfied with clothing and laundry.</p>	Residents' personal belongings are at times shared or go missing.	<p>To ensure a system to maintain ownership of personal belongings is maintained.</p> <p>180 days</p>
<p>Criterion 1.1.3.7</p> <p>Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.</p>	PA High	<p>Interviews with residents, family and staff confirmed that residents are not consistently receiving services that have regard for their dignity and privacy. Interviews with staff, residents and family, described verbal and physical abuse experiences, including residents being called inappropriate names, being slapped, having water poured over their body and residents sustaining bruises during interactions with staff. Through family and resident interviews there are reports that a staff member entered a toilet and enforced the resident to take their routine medication while sitting on the toilet. A verbal concern was raised with the audit team with regard to a resident sitting unclothed on the bed waiting for a staff member to answer the call bell to provide cares (refer 1.2.8.2), however, visitors, including children were able to view the resident through the open bedroom door. Document review showed that not all of the incidents were investigated or addressed through the complaints process (refer to 1.1.13.1). During the on-site audit the auditors observed staff not respecting the dignity of residents in the dementia unit (refer to 1.3.7.1). The residents and family survey identified 9 of 20</p>	Residents and family are not always respected or kept free from physical and verbal abuse and staff do not consistently maintain professional boundaries.	<p>Ensure the service provides a plan/system for how resident's respect is maintained, how they are kept free from abuse and or neglect and how staff will maintain professional</p>

		responses with concern around staffing.		boundaries. 7 days
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	PA Low	The service has an operations manual with a wide variety of policies, including clinical policies available to guide staff practices. Not all of these policies provide reference to current best practice and applicable legislation.	Some of the policies guiding staff practices do not include reference to current legislation and best practice.	<p>All policies to align with legislative requirements and current practice.</p> <p>180 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Moderate	<p>Resident and family interviews confirmed that most staff are approachable. Family and residents interviewed, however did express that they were cautious to approach some members of staff due to previous exposure to verbal abuse and episodes of physical abuse (refer to 1.1.3.7). Not all incident and accident records for issues, stated in interview by staff, residents and family, who complained about resident care, including incidents of verbal and physical abuse, could be verified. Interviews with staff confirmed they were aware of incidents of verbal abuse and a staff member being physically rough at times resulting in bruising/injury to residents.</p> <p>Resident and family interviews confirmed that the outcomes of surveys are not consistently discussed and that there is little evidence of how surveys contribute to quality improvement within the service. This was also evidenced in 7 of 20 responses by residents and family in the 2018 satisfaction surveys. Interviews with residents and families confirmed that feedback on changes in the facility was not consistently communicated and there are family members who were not aware of any resident meetings taking place.</p> <p>Resident and family interviews confirmed they are not kept informed regarding complaints and general service information, especially information regarding resident care in the dementia unit. Family interviews confirmed the service does not hold family meetings to specifically address issues and concerns of families of residents receiving dementia care.</p>	<p>i) Residents and family are not consistently informed or provided with information in relation to the outcomes of satisfaction surveys, complaints, resident meetings or general service information.</p> <p>ii) Admission agreements are not all signed or signed within 10 days of admission.</p>	<p>i) Residents and family have a right to full and frank information and open disclosure from the service.</p> <p>ii) Admission agreements to be all be signed and signed within 10 days of admission.</p> <p>90 days</p>

		Admission agreements reviewed were not all signed and those that were signed were not completed within the required 10 days from admission to the service.		
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective actions plans are in place for non-clinical incident and accidents, however, some of the clinical incidents that the audit team were made aware of, could not be verified (refer to 1.2.4.3). Where clinical incidents and accidents were documented (six were available for review), corrective actions could not consistently be verified. A variety of meeting minutes and internal audits were reviewed during the on-site audit. Records did not always evidence the person responsible for implementation of changes, timeframes for implementing changes or sign-off after changes were implemented. Interviews with residents and families confirmed that feedback on changes in the facility was not consistently communicated and there are family members who were not aware of any resident meetings taking place (refer to 1.1.9.1).</p>	<p>Corrective actions identified in meeting minutes, incident/accident records and complaints, do not consistently identify the person responsible for implementation, timeframes for and/or sign-off of corrective actions.</p>	<p>Ensure all corrective actions include the person responsible for implementation of changes, timeframes for implementation and sign-off once implementation of corrective actions occurred.</p> <p>180 days</p>
<p>Criterion 1.2.4.3</p> <p>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</p>	PA Low	<p>Service delivery is monitored through review of adverse event reporting in the form of incidents and accidents. Quality data is collated and information is included in monthly reports to the GM. Not all clinical related incidents and accidents are recorded and those documented did not record all aspects of the event, or appropriate corrective action implementation as a result of the adverse event (refer to 1.2.3.8).</p>	<p>Adverse event forms are not consistently fully completed.</p>	<p>Records for adverse event reporting to be fully completed.</p> <p>180 days</p>

manage risk.				
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA High	<p>Staffing policies and processes are in place to inform skill mix requirements. Rosters are prepared six weeks in advance. A clinical management team is in place to support care delivery.</p> <p>Staff turnover was raised as a concern by GPs (5 of 5), staff (15 of 15), residents (13 of 13) and family (10 of 10) through interviews. The 2018 resident and family surveys (9 of 20) reviewed also raised concern with staffing. All 13 local GPs through a formal letter to the board raised their concerns with staffing management and turn over. Interviews of the GPs, residents, their families and staff stated that staff turnover is high. Staff turnover was reviewed by the audit team and determined to have been around 50% in 2017 (38 staff left employment in 2017 of 76 current staff) and this is currently tracking at the same rate for 2018 (16 staff left employment to date January-May 2018 of 76 staff).</p> <p>It is noted in a board report (June 2017) that from 2014-2016 there were approximately 130 staff, with 119 staff leaving employment between 2014-June 2017. As at June 2017 there were 80 staff and at the time of the current on-site audit staffing numbers were 76. During the six weeks prior to the on-site audit, four staff members resigned; the CM, the clinical nurse leader, the chef and the maintenance person. The role of the CM was assigned to one of the currently employed RNs. The clinical nurse leader who left two weeks prior to the on-site audit, was not replaced and there was no evidence of processes having been implemented to replace this position. Interviews with staff confirmed that the CM also has a RN workload. The maintenance person was not replaced, and the gardener now has a dual role being also responsible for maintenance. The chef resigned the night prior to the on-site audit. During the on-site audit several staff who previously worked at the service as well as family who previously had loved ones in the care of the facility, contacted the audit team to voice their concerns about staffing. Interviews identified the work conditions, hours of work and workload as reasons for leaving employment.</p> <p>Police and criminal vetting occur. Overview of staff files identified employment of staff where there is knowledge of previous convictions. In aged care the Crimes Act of 1961 Section 151, due diligence should be applied to employment processes ensuring the safety of vulnerable adults, however there was no evidence that this occurred. Although staff, family and resident interviews confirmed multiple verbal and written complaints about staff behaviour, including a staff member introducing themselves as a medical doctor, not all</p>	<p>Practices around service provider availability do not currently ensure residents receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>The service to ensure service provider availability for residents to receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> <p>30 days</p>

		<p>incidents/complaints relating to staff were documented (refer to 1.1.3.7 and 1.1.13.1). In addition, review of staff files verified notices of performance issues for medicines errors. However, in spite of requests to obtain relating incidents and accident records, the audit team was not able to verify these medicines error incident/accident records (refer to 1.2.4.3 and 1.3.12.1).</p> <p>Employment processes do not consistently evidence best practice. There was no evidence of a letter confirming the new CM appointment or notification to HealthCERT that there was a change in clinical managers. The position was not formally advertised. There was a memo sent out by the GM for interested RNs to apply. One RN applied and was appointed. Although this individual has been working in the service, there is no evidence of prior clinical management experience. The outgoing CM was responsible for induction and orientation of the new CM, however, the auditors could not verify supporting documentation as evidence of this process. Review of the new CM's staff file did not include a job description for the new role, any documentation around the orientation/induction process or evidence that this RN has completed interRAI training.</p> <p>Rosters, on review, do not always reflect real time staffing. Rosters for the months of April 2017, April 2018 and May 2018 were reviewed. Six staff members' rosters were also reviewed to ascertain their work-hours over a week. All staff in this sample worked more than 40 hours per week, of which two worked more than 57 hours in one week. Feedback from staff is that they are contacted out of hours to work overtime due to gaps in the roster each week (approximately 18 gaps per week as per rosters reviewed). Staff, on interview, stated they felt pressured to work additional shifts to fill the gaps and spoke about often working 'short', with others working back to back or double shifts on consecutive days. Interviews with residents and families raised concerns that staff are over-worked.</p> <p>Allegations by staff interviewed, of rosters, prepared six weeks in advance, not reflecting real time staffing was reviewed. It was found that some of the rosters reviewed had names of staff recorded for shifts after they were no longer employed at the service, including a staff member on the roster who had not worked for the last couple of years at the facility and others on the roster who had begun orientation and after a few shifts had decided not to continue. Interviews confirmed that, particularly on night duty, the rosters do not reflect the actual allocation of staff. Staff come on duty and the RN in charge decides/re-allocates staff to ensure the best possible match of staff with service needs. There is a core group of caregivers (six) who are qualified to provide care in the dementia wing. Minimum staffing contractual requirements as per staff interview were</p>		
--	--	--	--	--

		<p>maintained, including the dementia unit.</p> <p>Staff interviews confirmed that new staff often leave before completing orientation and induction, leaving gaps in skill mix (refer to 1.1.3.7; 1.1.13.1; 1.3.3.3; 1.3.4.2; 1.3.5.2; 1.3.6.1; 1.3.7.1; 1.3.8.2; 1.3.8.3 and 1.3.12.1). This is exacerbated by induction and orientation process gaps, where staff orientation and induction may only occur in one specific area; for example; two-three shifts in the rest home, and then the new staff member is rostered on to work in the hospital or dementia wing. Interviews confirmed this.</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>	PA High	<p>The hardcopy/handwritten medication charts for respite residents evidenced they did not comply with current legislation requirements and safe practice guidelines.</p> <p>There were five residents who were being administered medications from hardcopy medication charts. Three of the five charts were handwritten medication charts and/or a prescription that was used to administer the medications.</p> <p>Two of the five residents were being administered medicines from a typed GP letter. This letter contained a list of the medicines the resident was taking and was not signed by the GP, did not have include the GP's name and contact details. Both respite residents have been residing at the facility since February 2018. One of the residents was being administered controlled drugs. This finding was discussed with the GM. The GM contacted the GP and presented the audit team with a GP signed, hardcopy, hand- written medication chart for both residents.</p> <p>There was one resident self-administering their medicines on audit days. Interview with the resident confirmed they were aware of their medications, the requirements for them and able to self-administer them. Resident's assessment for competency had been recorded and signed off by the RN and the GP. The medicines were located in a draw that was not locked. Following discussion with the GM about the storage of the medicines, the resident was provided with a locked draw for their medicine storage.</p>	<p>The medication management processes do not meet the legislative requirements and safe practice guidelines.</p>	<p>Provide evidence all medicine management processes align with legislative requirements and safe practice guidelines.</p> <p>7 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision</p>	PA Moderate	<p>The assessments and care plans are completed by RNs. GPs are informed of a new resident's admission to the facility and the GPs initial assessments occur in a timely manner. Residents whose condition changes are reassessed by GPs in</p>	<p>The service delivery timeframes are</p>	<p>Provide evidence service</p>

(assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		<p>a timely manner.</p> <p>There are areas of assessments, care plans and reassessment and evaluations that do not meet the required timeframes:</p> <p>i) The interRAI assessments were completed post the required three weeks of admission timeframe in four of the eight clinical files reviewed.</p> <p>ii) The GP written exemptions that the resident was stable for the resident to be reviewed three monthly were not sighted in two of the eight clinical files reviewed.</p> <p>iii) The activities assessments were not completed within the three weeks of the residents' admission to the facility in three of the eight clinical files reviewed.</p> <p>iv) The activities long-term care plans were not completed within the three weeks of the resident's admission to the facility in four of the eight clinical files reviewed. One of the four files evidenced the activities plan was completed four months post the resident's admission to the facility.</p> <p>v) The activities long-term care plans were not evaluated within the required six month timeframe in four out of eight files reviewed.</p> <p>vi) The long-term care plans that were completed within the three weeks of admission, were completed prior to the interRAI assessment being completed, in two of the eight clinical files reviewed.</p> <p>vii) The long-term care plans were not completed within three weeks of the residents' admission to the facility in three of the eight clinical files reviewed.</p> <p>viii) There was no evidence of risk reassessments, updating of a long-term care plan or a short-term care plan for a hospital resident who was transferred back to the facility from the DHB following a surgical intervention and a change to an increased level of care.</p> <p>ix) The dietary assessments were completed on admission, however, there has not been a six month review conducted in two of the eight clinical files reviewed.</p>	not always adhered to.	<p>delivery timeframes are being met.</p> <p>60 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of</p>	PA Moderate	<p>The NASC assessments are completed for each resident prior to admission.</p> <p>i) The initial assessment and the initial care plan of the rest home tracer was completed on the resident's admission to the facility, however, it was incomplete and did not include skin integrity assessment. The pressure injury assessment</p>	The required risk assessments are not consistently	Provide evidence the required risk assessment

consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.		<p>was completed five months post admission and recorded a rating of at risk of pressure injury, even though the resident had two pressure injuries that were being treated at the time of the assessment.</p> <p>ii) The residents presenting with pain on admission did not have pain assessments completed as evidenced in five of the eight clinical files reviewed.</p> <p>iii) One resident was identified as a falls risk, however, a full falls risk assessment was not completed.</p>	completed.	<p>are completed.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	All residents' long-term care plans were current. The residents' risk assessments are not always completed when required and as a result the long-term care plans do not describe the required interventions. The challenging behaviour care plans evidenced not all residents' behaviours that challenge were identified and the specific strategies were not recorded to manage the behaviours as evidenced in two of two clinical files reviewed of residents with dementia and one hospital resident's file.	Not all service delivery plans describe the required support and/or interventions to achieve the desired outcomes.	<p>Provide evidence all residents' service delivery plans meet residents' needs.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>The GP interviews confirmed the staff inform them in timely manner when a resident's condition requires review. One hospital resident's assessment identified a requirement for specialised equipment for pressure injury prevention, however, this was not provided two days post transfer from the DHB.</p> <p>The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were recorded and measurements taken where this was required. Where wounds required additional specialist input, this was initiated. Six of the fifteen wound care plans evidenced care that is not current best practice (e.g. the use of betadine).</p> <p>Two rest home residents required specialist interventions and treatment of their wounds, when the wounds deteriorated after being treated at the facility. There is evidence both residents required admission to the DHB for the wounds to be assessed and treated. The district nursing service is providing care and treatment at the facility for both residents following the residents' transfers from the DHB</p>	Residents' service delivery interventions are not fully reflective of residents' needs.	<p>Provide evidence residents' service delivery interventions are reflective of residents' needs.</p> <p>60 days</p>

		<p>back to the facility. There is no recorded evidence in the residents' files of the frequency, type of treatment and evaluation of the progress of the wounds by the district nursing staff. Management and staff were unable to report the progress of these wounds.</p> <p>Visual observation evidenced the residents' bathrooms were not provided with paper towels for residents' to be able to dry their hands. The corridor in the one of the wings of the facility had 1 paper towel dispenser and 3 hand gel dispensers for 14 residents' rooms.</p>		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>The residents and family interviews confirmed satisfaction with the activities provided at the facility. The 24 hour activities care plans are conducted by the clinical nurse leader and replicate the challenging behaviour care plans. There is no specific reference to timeframes or specific strategies for staff to follow during the 24 hour period detailing specific activities that may reduce behaviour that challenges and any triggers that may increase the behaviour. Interviews with DTs and an AC confirmed their completion of the activities assessments and the residents' activities care plans, however, no input into the 24 hour activities care plans. The residents' behaviours that challenge are recorded in residents' progress notes when they occur. The CNL stated they review the progress notes when present in the dementia unit, however, would not be able to evaluate the frequency of the events when the behavioural management care plan is reviewed six monthly.</p> <p>Two residents displayed behaviours of concern, observed by the audit team when visiting the dementia unit (e.g. one resident in a common area, was partially clothed – incontinence product and t-shirt and another was lying on the ground outside). There was no attempt by staff to take action in any form of diversion, care or support for these residents (refer to 1.1.3.7).</p>	<p>i) The 24 hour activity plan do not evidence individualised strategies to manage challenging behaviours.</p> <p>ii) Visual observation evidenced not all behaviour of concern are managed.</p>	<p>Provide evidence the 24 hour activity plans reflect strategies to manage individual resident's challenging behaviours and that behaviours are managed appropriately.</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of</p>	<p>PA</p> <p>Moderate</p>	<p>The long-term care plans reviewed were current. Interview with the RNs confirmed they input into the long-term care plan reviews.</p> <p>The long-term care plan evaluations did not indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome in two of eight residents' clinical files reviewed. The long-term</p>	<p>The care plan evaluations do not reflect the achievement or outcome of the documented</p>	<p>Provide evidence care plan evaluations are documented, consumer-</p>

achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.		care plan evaluation consisted of the date of review and the RN's signature.	interventions.	focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. 60 days
Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Moderate	When a resident's condition deteriorates this is communicated to the GP in a timely manner. The short-term care plans did not evidenced the required interventions and treatment of the short-term problems in four of the eight clinical files reviewed.	The short-term care plans do not consistently record the required interventions.	Provide evidence the short-term care plans record the required intervention to manage the short-term problems. 60 days
Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least	PA Low	Discussions with the CM and the GM relating to the infection control programme and the annual reviews of the programmes were conducted. Both managers were not able to locate this data for review. There was no recorded evidenced of the infection control programme available on audit days or evidence of annual reviews of the programme specific to this facility.	There was no recorded evidence of the infection prevention and control programme and the annual	Ensure the facility specific infection prevention and control programme is in place and reviewed

annually.			review.	annually. 180 days
<p>Criterion 3.3.1</p> <p>There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.</p>	PA Low	<p>The six facility specific infection control policies are current.</p> <p>There six policies related to infection control implementation and management; infection control programme; infection control team meeting schedule; notification diseases; pandemic plan; and vaccination programme. A written statement by the GM records the infection control at the facility comprises of the above policies and follows the infection control manual of an external provider.</p>	<p>The infection control manual is a generic resource manual and not reflective of the facility's specific processes.</p>	<p>Ensure the infection control policies and procedures reflect of the type of services provided at the facility.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.